



KENTUCKIANA
— COURT REPORTERS —

Case No. 3:20-cv-1123-JDP

Gregory Boyer

V.

Advanced Correctional Healthcare, Inc., et al.

Case No. 3:22-cv-00723-JDP

Gregory Boyer

V.

USA Medical & Psychological Staffing, Inc., et al.

DEPONENT:

KIMBERLY PEARSON

DATE:

February 26, 2025



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1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE WESTERN DISTRICT OF WISCONSIN

3 -----
4 Gregory Boyer,

5 Plaintiff,

6 -VS-

Case No. 3:20-cv-1123-JDP

7 Advanced Correctional Healthcare, Inc., et al.,

8 Defendants.
9 -----

10 Gregory Boyer,

11 Plaintiff,

12 -VS-

Case No. 3:22-cv-00723-JDP

13 USA Medical & Psychological Staffing, Inc., et al.,

14 Defendants.
15 -----
16
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18 * * * * *

19 VIDEOCONFERENCE DEPOSITION OF KIMBERLY PEARSON

20 TAKEN ON THE 26TH DAY OF FEBRUARY, 2025

21 10:02 A.M. CST

22 REMOTELY VIA ZOOM

23 * * * * *
24
25

APPEARANCES:

MARIA MAKAR and MADISON IRENE, of the firm of LOEVY & LOEVY, 311 North Aberdeen Street, 3rd Floor, Chicago, Illinois 60607, appeared remotely via Zoom representing the Plaintiff.

DOUGLAS KNOTT and DANIEL KAFKA, of the firm of LEIB KNOTT GAYNOR, 219 North Milwaukee Street, Suite 710, Milwaukee, Wisconsin 53202, appeared remotely via Zoom representing the Defendants Advanced Correctional Healthcare, Inc., Lisa Pisney, and Amber Fennigkoh.

MARK W. HARDY, of the firm of GERAGHTY O'LOUGHLIN & KENNEY, P.A., Wells Fargo Place, 30 East Seventh Street, Suite 2750, St. Paul, Minnesota 55101, appeared remotely via Zoom representing the Defendants USA Medical & Psychological Staffing, Inc., Travis Schamber, and Norman Johnson.

ANDREW A. JONES, of the firm of HANSEN REYNOLDS, LLC, 301 North Broadway, Suite 400, Milwaukee, Wisconsin 53202, appeared remotely via Zoom representing the Defendants Monroe County, Stan

Hendrickson, Danielle Warren, and Shasta Parker.

ALSO PRESENT VIA ZOOM: Alecia Richards
Lauren Hill

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EXHIBITS

- 1 Curriculum Vitae
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- 4 Narrative Note - previously marked Exhibit 6
- 5 Intake medical screening report - previously
marked Exhibit 3

(Original exhibits were retained by Attorney
Irene)

1 THE VIDEOGRAPHER: My name is Talia
2 Jackson. I'm the online video technician
3 representing Kentuckiana Court Reporters
4 located at 730 West Main Street, Suite 101,
5 Louisville, Kentucky 40202, and Terri Stacken
6 is the court reporter today.

7 Today is the 26th day of February,
8 2025, and the time is 10:02 a.m. Central.

9 We are convened by videoconference to
10 take the deposition of Kim Pearson in the
11 matter of Gregory Boyer vs. Advanced
12 Correctional Healthcare, Inc., et al., and in
13 Gregory Boyer vs. USA Medical & Psychological
14 Staffing, Inc., et al., pending in the United
15 States District Court for the Western
16 District of Wisconsin. Case No.
17 3:20-cv-1123-JDP and Case No.
18 3:22-cv-00723-JDP.

19 Will everyone but the witness please
20 state your appearance, how you're attending,
21 and the location you're attending from
22 starting with Plaintiff's counsel.

23 MS. IRENE: Hi. My name is Madison
24 Irene. I am representing Plaintiff Christine
25 Boyer, and I'm appearing virtually over Zoom

1 from Chicago, Illinois.

2 MR. KNOTT: Hi. This is Doug Knott.
3 I'm appearing along with my colleagues Lauren
4 Hill, who's a paralegal, Daniel Kafka, who's
5 an associate. We appear for the witness. We
6 appear for Advanced Correctional Healthcare,
7 for Lisa Pisney, and for Amber Fennigkoh.

8 MR. JONES: I am Andrew Jones. I'm
9 appearing by Zoom from Milwaukee. I
10 represent Monroe County, Stan Hendrickson,
11 Danielle Warren, and Shasta Parker.

12 MR. HARDY: I am Mark Hardy. I'm
13 appearing on behalf of USA Medical &
14 Psychological Staffing, Norman Johnson, and
15 Travis Schamber, and I'm appearing by Zoom
16 from Minneapolis, Minnesota.

17 THE VIDEOGRAPHER: All right. And I
18 believe Ms. Richards is joining. I think
19 that's the intern, so I'm just going to let
20 her in before we continue.

21 Now, Ms. Pearson, can you please state
22 your name for the record.

23 THE WITNESS: Yes. Kimberly Pearson.

24 THE VIDEOGRAPHER: Thank you. And,
25 Counsel, once again, off record you indicated

1 that we would stipulate to the identity of
2 Ms. Pearson.

3 Is that still true?

4 MS. IRENE: Yes.

5 MR. KNOTT: Yes.

6 THE VIDEOGRAPHER: All right. Then
7 Ms. Pearson, can you please raise your right
8 hand to be sworn in by the court reporter.

9 KIMBERLY PEARSON,
10 after having been first duly sworn on oath by
11 Terri Stacken deposes and says as follows:

12 EXAMINATION

13 BY MS. IRENE:

14 Q Okay. Good morning, Ms. Pearson.

15 A Good morning.

16 Q I want to begin just by covering a few ground
17 rules. As you're aware, there's a court reporter
18 here and she's going to be taking down everything
19 that we're saying. So we like to try to give
20 loud and verbal answers. Try not to head nod or
21 shake your head. Respond verbally. And try your
22 best not to respond with things like uh-hum
23 because it will just make it easier for the court
24 reporter to understand you.

25 I will try my best to talk one at a time so

1 as to not confuse the court reporter as well. If
2 I interrupt you accidentally, please tell me,
3 because I want you to finish all of your answers
4 completely.

5 Does that make sense?

6 A Yes.

7 Q And if you don't understand a question, please
8 say that or ask for further clarification. If
9 you do answer a question, I will assume that you
10 did understand the question.

11 You may hear counsel objecting throughout
12 this. That's okay. Please still answer the
13 question even if it's been objected to unless
14 counsel otherwise instructs you not to.

15 Do you have any conditions that affect the
16 truthfulness or accurateness of your memory?

17 A No.

18 Q Are you on any medications?

19 A No.

20 Q Okay. I'm going to ask you about the opinions
21 listed in your report, and I'm not going to ask
22 you to offer opinions that are not already
23 disclosed in that report.

24 Does that make sense?

25 A Yes.

1 Q Have you been deposed before?

2 A Yes.

3 Q About how many times have you been deposed
4 before?

5 A Somewhere between 30 to 40 times.

6 Q And have you ever been a main party in a
7 deposition, so a plaintiff or a defendant?

8 A Yes.

9 Q When was that?

10 A It was approximately I would estimate 2016 or
11 '17.

12 Q And were you the plaintiff or the defendant?

13 A Defendant.

14 Q And what was that case regarding? What was it
15 about?

16 A It was regarding a death in a jail.

17 Q And what was the outcome of that case?

18 A I don't recall. I was dismissed.

19 Q And do you remember the name of that case?

20 A Not as I sit here today, no.

21 Q Have you ever been -- so in that case were you
22 being sued?

23 A I was named in that suit again and then
24 dismissed.

25 Q And is that the only case in which you've been a

1 **defendant?**

2 A To the best of my recollection, yes.

3 Q **Did you prepare for your deposition today?**

4 A Yes.

5 Q **And how did you prepare for your deposition?**

6 A I reviewed my case file, reviewed the records,
7 reviewed my report.

8 Q **Did you meet with any attorneys?**

9 A Yes, I did.

10 Q **Who did you meet with?**

11 A Mr. Knott.

12 Q **And how many times did you meet with Mr. Knott?**

13 A For deposition preparation, once.

14 Q **Yes. And when was that?**

15 A Yesterday.

16 Q **And for about how long did you meet?**

17 A Couple of hours.

18 Q **And was anyone else present at your meeting with
19 him?**

20 A No.

21 Q **And you said that you reviewed some materials for
22 your deposition.**

23 **You said you reviewed your report?**

24 A Yes, among other -- anything in the case file;
25 the records, anything that I had received in

1 order to write my report.

2 Q And about how many times did you review these
3 materials?

4 A I don't understand that question.

5 How many times?

6 Q Yes. Did you look over your report once, did you
7 look it over twice, three times in preparation
8 for this deposition?

9 A I couldn't put an answer to that. I prepared for
10 two and a half hours, so. I would be going back
11 and forth between documents. It's hard to put a
12 number on how many times I read one specific
13 document.

14 Q Okay. Did you speak with anyone else about your
15 deposition today?

16 A No.

17 Q And aside from reviewing the -- those materials
18 that you mentioned and meeting with Mr. Knott did
19 you do anything else to prepare?

20 A No. I don't believe so.

21 Q What is your current rate for your services?

22 A My current rate for review of records, writing
23 reports, is \$450 per hour. For deposition it's
24 \$500 per hour.

25 Q And did you sign a retainer agreement with any of

1 the defendants in this case?

2 A No, I did not.

3 Q And when you've worked as an expert in cases in
4 the past how do you typically bill your
5 clients?

6 A I bill them for work and services provided.

7 Q And how do you give them -- how do you tell them
8 what work and services you provided?

9 A I provide a detailed invoice.

10 Q And as you work on a project how do you keep
11 track of your hours?

12 A I have a software program that has a timer and I
13 use the timer anytime I'm reviewing anything, and
14 I document exactly what I've reviewed so that I
15 can provide that detail in the invoice.

16 Q Do you remember the name of the software program
17 that you use?

18 A I believe it's MyCase.

19 Q And in a typical case about how often do you
20 issue a bill?

21 A My main -- my typical practice is to bill
22 monthly.

23 Q And what's the total amount you've billed in this
24 case to date?

25 A Well, prior to deposition preparation, over the

1 course of almost three years, I've billed
2 approximately 45 hours.

3 Q And do you know what the amount would be?

4 A I'd need to get my calculator out to do that.

5 Q That's fine. And so you've already issued bills
6 to Defendants in this case?

7 A I've submitted bills to Mr. Knott's firm.

8 Q So when you said that you worked about 45 hours
9 on this case before the deposition today, over
10 what period of time -- you said that period --
11 sorry. I withdraw that question.

12 You previously stated you worked about 45
13 hours of this case, and did you say that that was
14 over a period of three years?

15 A Not quite three years, but close. It would have
16 been May of '22.

17 Q And were those 45 hours mostly worked on at one
18 time 40 hours a week or has it been spread out
19 across three years?

20 A No, it's spread out as documents become
21 available, deadlines, report deadlines.

22 Q Do you know about how many hours you'll be at
23 including the deposition -- or the deposition
24 preparation?

25 A Approximately maybe an additional five hours.

1 Q So do you have an approximate total bill for this
2 case?

3 A No, because I bill monthly, so I would have to
4 pull all of those and do the math.

5 Q Did you bring any record of the hours that you've
6 billed in this case today?

7 A Did I bring it? No. No.

8 Q And will you bill for every hour that you work on
9 this case?

10 A Well, honestly, I under bill. I do a lot of
11 thinking that I don't bill for, frankly, so. I
12 will bill for legitimate work hours. I'm very
13 conscientious about being ethical in that
14 arena.

15 Q What's the reason you feel like you under bill?

16 A Well, again, I think about things. You know, I
17 may be getting ready for my day this morning and
18 just thinking as I was preparing getting dressed
19 this morning about the case. I'm not billing for
20 that.

21 Q Are those things that to your knowledge other
22 experts typically bill for?

23 A I don't ask. I don't -- I don't know. It's just
24 my practice.

25 Q Are there any other reasons that you feel like

1 **you under bill?**

2 A Well, again, I'm just trying to answer the
3 question as you asked it. You wanted to know if
4 I bill for every single thing that I've done, and
5 I'm just letting you know that I think about
6 these cases and I don't always bill for the time
7 that I may be thinking about something. Again,
8 this morning getting ready I was thinking about
9 the deposition. I'm not billing for that, so.

10 I bill for time of exactly what's on my fee
11 schedule; records reviewed, development of
12 report, preparation, those types of things.

13 Q Thank you. Yes, I'm just -- I'm -- I don't bill
14 like that, so I'm just trying to get a better
15 understanding of your -- of your billing
16 practices and what you do and don't bill for.

17 Okay. I'm now going to briefly -- I'm going
18 to take myself off and pause for a moment to
19 share my screen.

20 Can you see my screen clearly?

21 A Yes, ma'am.

22 Q I'm marking this as Plaintiff Exhibit 1.

23 Do you know what this is?

24 A That's the first page of my CV.

25 Q And is this your most current and up-to-date

1 CV?

2 A Can you -- can you stop?

3 Q Yes, I'll go slower. Sorry.

4 A I just need to see the date on the second page.

5 1-1-25. Yes, it is.

6 Q And is everything on it true and accurate?

7 A Yes. To the best of my knowledge, yes.

8 Q What degrees do you have?

9 A As on page 2, a master in business
10 administration, a master of science in healthcare
11 administration, a Bachelor of Science in health,
12 and a diploma in nursing.

13 Q Were you ever put on academic probation at any
14 time?

15 A No.

16 Q Can you talk to me a bit more about the first job
17 that you had.

18 What were your responsibilities there?

19 A Which one are you referring to?

20 Q Well, I guess I'll ask you. Is this El Camino
21 Hospital-Mountain View, the psychiatric unit,
22 assistant nurse manager, was that your first
23 job?

24 A No. I've worked since I was in high school.

25 These are relevant nursing positions.

1 Q So was that your first job that you worked after
2 you got your diploma in nursing?

3 A I -- I may have worked for a nursing home for a
4 few months while I was in transition moving to
5 California. But essentially, yes, this was my
6 first nursing job.

7 Q Why did you leave the nursing home position?

8 A Well, again, I was moving from Illinois to
9 California, so it was -- I just was paying my
10 bills and getting ready to move and moved and
11 then took this position in California.

12 Q So this position at the El Camino Hospital was
13 your second job after receiving your diploma in
14 nursing?

15 A Perhaps.

16 Q Is there some reason that you believe you would
17 have worked other jobs in between that?

18 A No.

19 Q And what were your responsibilities there?

20 A Well, I worked, as is noted there, on the medical
21 unit, the nephrology unit, the psychiatric unit,
22 and then was an assistant nurse manager for a
23 time.

24 Q And why did you leave that position?

25 A I relocated to Illinois.

1 Q And when you relocated to Illinois was your first
2 job there at this Proctor Hospital as a nurse
3 manager?

4 A Yes.

5 Q And what were your responsibilities as a nurse
6 manager?

7 A I was the nurse manager of the medical
8 respiratory unit. I was responsible for all of
9 the patient care in that unit, for nurse hiring,
10 nurse training, budget, all of the things that a
11 nurse manager is responsible for.

12 Q Okay, yes. Thank you. Sorry, I'm asking these
13 questions because I don't know all the things
14 that nurse managers are responsible for, so it's
15 helpful to clarify.

16 And why did you leave that position?

17 A I had an opportunity at OSF Saint Francis that I
18 wanted to take.

19 Q And what made that opportunity more attractive to
20 you?

21 A It's where I went to school and it's where I
22 wanted to ultimately work. It's a trauma center.
23 It gave me extensive clinical experience, much
24 more well-rounded.

25 Q And after that you have listed OSF Saint Francis

1 Medical Center, so the same place, but emergency
2 medical services systems manager.

3 A Yeah.

4 Q Was that change in job a promotion or was it just
5 a change to a different department, different
6 responsibilities?

7 A I guess I would say it's a change in
8 responsibilities, different department.

9 Q And what were your responsibilities in emergency
10 medical services?

11 A I was responsible for the largest EMS system in
12 the State of Illinois in terms of EMS provision
13 to the communities. I believe I had 2100
14 paramedics and EMTs in my system. I was
15 responsible to ensure their training and
16 licensure was adequate. We provided training.

17 I also headed up -- it was shortly after
18 9-11. Homeland Security dollars were flowing for
19 systems to create disaster response teams, so I
20 put together disaster response teams to provide
21 services to the outlying communities in the
22 region.

23 Q And why did you leave that position?

24 A I relocated to New Mexico.

25 Q And in New Mexico it says you worked at Gallup

1 **Med Flight.**

2 **Can you talk -- what is Gallup Med Flight?**

3 A Gallup Med Flight's a medical flight program. It
4 was critical care flight transport out of Gallup
5 to larger facilities.

6 **Q And why did you leave that position?**

7 A That position was 24/7 and -- literally. I was a
8 flight nurse. And it just was -- it became
9 somewhat exhausting, honestly, all the hours, so
10 I made a move to something a little more family
11 friendly.

12 **Q And you were in New Mexico until 2009; is that**
13 **right?**

14 A Yes.

15 **Q And then you went to the Orange County Health**
16 **Care Agency in Santa Ana, California; is that**
17 **right?**

18 A Yes.

19 **Q And what made you make that move?**

20 A Moved to California.

21 **Q And why did you want to work for Orange County**
22 **Health Care Agency in Correctional Health**
23 **Services?**

24 A I had an interest in serving that population.

25 **Q Can you describe your current role at KP**

Consulting.

A So I provide correctional health care consulting services to jails and prisons across the country. I look at -- I do a lot of things in my consulting program.

I have worked on behalf of the Board of Registered Nursing in cases, reviewing cases in correctional settings. I've worked with private healthcare companies. I've worked with counties developing their contracts, doing their RFP development, worked with the National Commission on Correctional Health Care doing technical assistance inspections for different counties.

It's very varied the projects, but it's all correctional health related.

Q Just to clarify, everything that KP Consulting does is correctional health related or everything that you do at KP Consulting is correctional health care related?

A Both. It's my company.

Q And how many other people are employed at your company?

A None.

Q And is my understanding correct that you serve both as program consulting regarding

1 administrative and clinical operations and as
2 expert -- an expert witness for correctional
3 health care cases?

4 A Yes.

5 Q And can you estimate about what percentage of
6 your work is working as a program consultant.

7 A Well, I'm going to answer that in this way. I
8 have decided to retire, and so I stopped taking
9 new cases last year. I also stopped taking
10 consulting projects. I just recently in the last
11 four weeks turned two down.

12 And so at this point I am just trying to
13 finish up depositions and trials that are left on
14 my calendar.

15 Q Well, congratulations on retiring. But so I
16 guess before, from 2014 to I guess 2024, can you
17 estimate about what percentage of your work was
18 working as a program consultant.

19 A Oh, that's a little complicated too. It's not a
20 simple answer, because from 2014 until 2018 I was
21 working at Orange County Health Care Agency, so I
22 was doing some expert work very, very part-time
23 during 2014 to '18.

24 Then I retired from Orange County in 2018,
25 and that's when I started doing both. I was

1 doing consulting at that point.

2 Typically, I would -- how it unfolded was I
3 think the most that I would bill is about 40
4 hours. I worked full-time, so 40 hours in any
5 given month on expert case review and otherwise
6 it was in various consulting projects. So maybe
7 a fourth of my time.

8 **Q Looking at -- or thinking about all the jobs that**
9 **you've ever worked at, have you ever received any**
10 **disciplinary action in any of your jobs?**

11 **A Absolutely not.**

12 **Q And were you ever fired from any of your jobs?**

13 **A No.**

14 **Q I'm marking this as Plaintiff's Exhibit 2.**

15 **Do you recognize this?**

16 **A Yes.**

17 **Q And what is this?**

18 **A A case testimony list that's required by**
19 **Rule 26.**

20 **Q So as of now how many cases are you currently**
21 **handling?**

22 **A As of right now?**

23 **Q Yes.**

24 **A I would estimate 17 are open. However, I only**
25 **believe that there are about nine with**

depositions or trials on the calendar.

Q And before you retired did you have -- can you estimate the amount of cases you handled in your capacity as an expert witness.

A Well, due to the nature, I mean, I have cases that date back to 2015, honestly. So some of these cases go on, unfortunately, for nine, 10 years. So, you know, some of those cases I hadn't even looked at in multiple years.

But I would say before I decided to retire I probably had about 45 total caseload that was open. Again, many just sit there and there is no action. And every year I have a practice in January of contacting all of my open case attorneys to see what's going on with the cases because very, very frequently experts are not informed when cases have settled or, and so I typically every January close out multiple.

Q This case testimony list, this is every case that you've ever testified in trial for --

A No.

Q -- for the last four -- sorry, I apologize. For the last four years; right?

A For the last four years, yes.

Q So before these last four years do you know about

1 how many cases you testified as an expert in
2 trial for?

3 A No. I don't recall off the top of my head.

4 Q Do you know if it was dozens?

5 A No. No.

6 Q In any of these cases were you testifying on
7 behalf of the plaintiff? I apologize. I'll
8 withdraw that question.

9 Looking at this, at your case testimony, in
10 any of these cases listed on this document were
11 you testifying on behalf of a plaintiff?

12 A On the entire document?

13 Q Yes. And if you need a minute to look it over,
14 that's more than fine too.

15 A Right. Right. Again, this is a four-year
16 snapshot, so I have certainly testified on behalf
17 of plaintiffs before. But this four-year
18 snapshot, you know, there is -- there is -- there
19 is a plaintiff case in here definitely.

20 Q Which case is that?

21 A Pendermon vs. Hounshell.

22 Q And is that the only case on this list in which
23 you testified on behalf of a plaintiff?

24 A Yes. Again, on this particular four-year list.
25 I have testified on behalf of plaintiffs in other

1 matters.

2 Q About how many times have you testified on behalf
3 of a plaintiff?

4 A I can't provide you an answer to that without
5 going through my entire case file.

6 Q Are you able to estimate the proportion of cases
7 that you worked on where you were retained by a
8 plaintiff?

9 A Yes. Yes, I can estimate. 25 percent.

10 Q And looking again at your case testimony sheet,
11 have you -- I apologize about that -- have you --
12 do any of these cases involve claims of injury
13 from a significant delay of medical care?

14 A I'd have to go through. I don't recall all the
15 specifics of these cases. I apologize. I don't
16 recall.

17 Q Okay. How do you go about getting your work?

18 A I'm sorry, what?

19 Q How do you go about getting your work? How do
20 you go about -- how -- how do you go about
21 getting these expert witness positions in these
22 cases?

23 A I'm contacted by an attorney, and then we have a
24 discussion about their needs and my availability
25 and if I can help them, if I have a conflict,

1 whatever it may be, and then I either accept the
2 review or not.

3 **Q And do you advertise?**

4 **A No.**

5 **Q Have you ever been excluded as an expert witness**
6 **in a case before?**

7 **A No, I have not been excluded.**

8 **Q In what subject areas do you consider yourself to**
9 **be an expert in?**

10 **A Well, my focus is solely correctional health. So**
11 **correctional health administration, operations,**
12 **nursing. I think that covers all of it.**
13 **Administration, operations, and nursing.**

14 **Q Okay. Sorry. And are there any subject areas**
15 **that you do not consider yourself to be an expert**
16 **in?**

17 **A I'm not even sure how to answer that question.**

18 **Could you ask it in a different way?**

19 **MR. KNOTT: Objection. Overly broad.**

20 **Q (By Ms. Irene, continuing) Is there anything to**
21 **do with, for example, any of the -- sorry, I'll**
22 **withdraw that.**

23 **When it comes to correctional health care**
24 **administration, is there any subject or part of**
25 **that in which you, for example, would say I**

1 really know this stuff, but I don't know this.
2 This is a part of correctional health care that
3 may come up regularly but I've never worked in
4 that, I'm not an expert in it?

5 MR. KNOTT: Object to the form of the
6 question. But you may answer.

7 A Well, it depends. I really -- I don't know how
8 to answer that question. I mean, it would depend
9 on the circumstances that were presented. I
10 would just need to review the facts. And if it's
11 something that I did not feel I had experience
12 in, then I would certainly relay that information
13 to the attorney.

14 Q (By Ms. Irene, continuing) Okay. I'm going to
15 show you Plaintiff's Exhibit 1 again. This is
16 your CV.

17 Looking at your Professional Affiliations,
18 can you tell me what Jail Accreditation Surveyor
19 is.

20 A Yes. So the National Commission on Correctional
21 Health Care provides accreditation to facilities
22 who choose to pursue accreditation. Similar to
23 if you do medical cases similar to the Joint
24 Commission provides accreditation for hospitals,
25 National Commission provides accreditation for

1 jails.

2 When a jail or a prison wants to pursue
3 accreditation, then an accreditation team of
4 surveyors comes into the facility for several
5 days, does a lot of work in advance as well
6 reviewing policies and procedures, and then looks
7 at all their clinical operations, administrative
8 operations in light of and in comparison to the
9 standards to determine whether they meet
10 accreditation standards.

11 **Q Okay. And can you tell me more about your**
12 **association with the American Correctional Health**
13 **Services Association.**

14 **A** American Correctional Association?

15 **Q Yes.**

16 **A** Is that what you said?

17 **Q Yes. American Correctional Health Services**
18 **Association.**

19 **A** Oh, okay. Yes. So I was a previous chapter
20 board member for that association for several
21 years. And the primary goal of that association
22 at the time was to provide educational content
23 for correctional health professionals in
24 California and Nevada and Oregon and Washington,
25 I believe.

1 Q Okay. And looking at your Professional
2 Certifications, can you talk to me more about
3 what your CCHP certification is?

4 A Yes. So the National Commission on Correctional
5 Health Care offers individuals the opportunity or
6 option to be a Certified Correctional Healthcare
7 Professional.

8 And so that requires working in the field as
9 well as sitting for an exam, successfully passing
10 that proctored exam, and then maintaining and
11 submitting annual continuing education hours to
12 support recertification, and with the vast
13 majority of those being in correctional
14 health-specific issues.

15 Q And what's your Six Sigma Green Belt
16 certification?

17 A So Six Sigma is a process-driven methodology
18 that -- it's well-known in manufacturing
19 specifically, but it's really about process
20 evaluation. And so when I was at Saint Francis
21 Medical Center in Illinois they developed a Six
22 Sigma team to look at processes.

23 And so the thought is that rather than a
24 nurse manager who's doing a hundred different
25 things over the course of the day and is putting

1 out fires rather than proactively trying to
2 identify and manage and mitigate problems, the
3 Six Sigma team comes in and they are just
4 dedicated to that -- dedicated to that project
5 and problem.

6 So, for instance, if -- one of the projects
7 we worked on was we were seeing an increase in
8 pneumonia in our ICU patients on ventilators. So
9 this team went in and started going through all
10 of the documents, it's extensive review,
11 analysis, problem-solving, that kind of
12 methodology. So it's really research and
13 methodology and process management.

14 **Q Okay. Looking at your Consulting Contracts, the**
15 **first one that says expert witness and**
16 **correctional health care consultant, is -- what**
17 **is that contract?**

18 **A** Well, it's not a contract. That's just a -- it's
19 just providing information about one of the
20 things that I do. Some of them have a written
21 contract. Some of the projects do not.

22 **Q Okay. So looking at, for example, Medical**
23 **Horizons Consulting, what -- why do you have that**
24 **listed as a consulting contract? Can you explain**
25 **to me more about what that is?**

1 A Sure. This is just a chronology just showing
2 my -- the history of my clinical experience.

3 And so again, after being in the EMS venue
4 and being a disaster response leader for the
5 State of Illinois, I was hired -- a consulting
6 contract with Medical Horizons back in it says
7 2009-2010, public health and disaster
8 preparedness. And so I was assisting them with
9 various projects based on my clinical expertise
10 at the time.

11 Q Okay. So you've done consulting work also on
12 oncology administration?

13 A Yes.

14 Q And on medical malpractice?

15 A Yes.

16 Q And have you ever served as an expert witness for
17 any of these other things that you did consulting
18 work for aside from correctional health?

19 A Could you repeat the question, please?

20 Q Have you ever served as an expert witness on any
21 of these other things that you did consulting
22 work for aside from correctional health?

23 So, for example, have you ever served as an
24 expert witness on disaster preparedness?

25 A Understood. No, I have not.

1 Q Okay. And looking at your -- the list of
2 Publication Review, Presentations, and Teachings,
3 did you do a manuscript review for The Nurse
4 Practitioner, "The Implications of eDiscovery for
5 the Nurse Practitioner".

6 A Yes.

7 Q And what was that about?

8 A That was --

9 MR. KNOTT: I'm sorry, could you --
10 could you -- you're on page 4, and could you
11 take me to that? Tell me approximately where
12 that is.

13 MS. IRENE: Yes. At the top of page 4
14 of Plaintiff's Exhibit 1, actually.

15 MR. KNOTT: Okay. Thank you.

16 Q (By Ms. Irene, continuing) You can answer,
17 please.

18 A So that was from 2019, so I honestly don't recall
19 all of the content in that particular article.

20 However, I will say that because of my
21 extensive work in electronic healthcare records,
22 it was really not so much about a nurse
23 practitioner. It was more focused on the
24 eDiscovery, electronic record, that type of
25 thing.

1 So I just reviewed it from a content
2 standpoint and then provided my input as to --
3 well, you provide a lot of different input on
4 manuscript review in terms of the resources they
5 used and the content.

6 Q And in 2018, in the fall of 2018, were you
7 interviewed for a journal publication called
8 "Tales from the Court: Experienced LNCs at Trial
9 and Deposition" by the American Association of
10 Legal Nurse Consultants.

11 A Yes.

12 Q And what was that interview about?

13 A I honestly do not recall.

14 Q And in September of 2017, I'm looking still at
15 page 4 of Plaintiff's Exhibit 1 towards the lower
16 half, were you a speaker at the California-Nevada
17 Chapter Conference for the American Health
18 Services Association at an event called "Clinical
19 Management for High-Risk Patients in this
20 Litigious Environment."

21 A No, not as you stated it. It was for the
22 American Correctional Health Services
23 Association, and it was not -- the event was not
24 called "Clinical Management for High-Risk
25 Patients in this Litigious Environment". That

1 was the name of a presentation.

2 Q And you were a speaker at that presentation?

3 A Yes.

4 Q And do you remember what you spoke about?

5 A High-risk patients in jail and prison settings.

6 Q And do you remember anything more specific you
7 were speaking on that subject about?

8 A Not specifically, no.

9 Q And looking at the top of page 5, were you a
10 speaker for the California State Association of
11 Counties at their annual conference in Palm
12 Springs, California, December 2016, at a talk
13 that was titled "Responding to Inmate Advocacy
14 Groups and Preventing Jail Lawsuits".

15 A Yes.

16 Q And do you remember what you spoke about?

17 A No, I do not. It was a panel discussion, so it
18 would have consisted of a lot of questions and
19 answers.

20 Q Okay. Sorry. Just give me one moment. And in
21 December of 2016, I'm still looking on page 5,
22 did you do a manuscript review of a work that was
23 titled "Being a Culturally Competent Nurse: A
24 Nursing Student, Why and How".

25 A Yes.

1 Q And it says Nursing 2016. Is that a journal? A
2 magazine? What is that?

3 A Yes. It's a journal slash magazine. It's
4 Nursing, and every year the title changes to the
5 current year. So this year it's Nursing 2025.
6 That year it was Nursing 2016.

7 Q Okay. And sorry, I only have a few more of these
8 for you. In -- looking at page 6 now of
9 Plaintiff's Exhibit 1, in April of 2013 did you
10 do a manuscript review for that same Nursing 2013
11 titled "When Patients Are Also Inmates:
12 Providing Nursing at a Correctional Facility".

13 A Yes.

14 Q Okay. And then in July of 2007, looking at the
15 top of page 7, did you do a manuscript review for
16 Nursing 2007 on an article titled "Code STEMI: --
17 S-T-E-M-I -- Better Care for Cardiac Patients".

18 A Yes.

19 Q And what is Code STEMI?

20 A I don't recall anything about this article,
21 frankly, from 2007.

22 Q Okay. Thank you. One moment. I'm going to stop
23 sharing my screen.

24 Okay. Ms. Pearson, in your review of
25 materials for this case, were there any materials

1 that you asked for but were not provided?

2 A No.

3 Q And is it fair to say that attorneys selected the
4 documents that you reviewed?

5 A Yes, I suppose I would say that's fair. They
6 sent me the records they wanted me to review.

7 Q Is there any reason that you feel like that's not
8 an accurate statement?

9 A How this process works for me is I'm sent
10 materials by the retaining attorney. And if
11 there's something that is referenced that I don't
12 have or that I think I need I ask for that, and
13 they may or may not have it, and that's just how
14 the process works.

15 So I don't know how they determine -- well,
16 let me say this. There are certainly things if
17 I've been asked to opine on one thing, I may not
18 need 10 things that aren't related to that, and
19 that's their decision. Again, I accept and
20 review what they send. And if I need something
21 different, I believe I need something different,
22 I ask.

23 Q Okay. And in this case you did not ask for
24 anything additional?

25 A I don't believe so.

1 Q Is there any reason why you didn't ask to see
2 anything other than the materials that you were
3 given?

4 MR. KNOTT: Form.

5 A Did someone say something?

6 MR. KNOTT: I objected to the form.

7 I'm sorry. I maybe need to speak a little
8 bit to catch my microphone.

9 A So I received documents that I felt were
10 appropriate for me to formulate my opinion.

11 Q (By Ms. Irene, continuing) Okay. I'm going to
12 share my screen again. Is this -- can you all
13 see this as well? Is this screen sharing in the
14 way on the top of this document? I'll just try
15 to move it. I don't know if you can see it or
16 not.

17 Ms. Pearson, do you recognize this?

18 A Yes.

19 Q And what is this?

20 A That is the report that I authored related to
21 this case and submitted.

22 Q And is everything in your report true and
23 accurate?

24 A To the best of my knowledge, yes.

25 Q Okay. In general, as serving as an expert

1 **witness on correctional health cases, what**
2 **methodologies do you use to review materials?**

3 A So I review the materials that are provided to
4 me. And then based on my training, my education,
5 my licensure and scope of practice and my
6 experience, 40 years in nursing, and in
7 correctional health since 2010, then I formulate
8 my opinion based on all of those things
9 combined.

10 Q **And what methodologies did you use in your**
11 **analysis of this case?**

12 A Same.

13 Q **What does the term "standard of care" mean?**

14 MR. KNOTT: Object to the form of the
15 question. To the extent it calls for a legal
16 conclusion, but -- or a legal definition.

17 But you can go ahead and answer.

18 A My -- how I would describe standard of care based
19 on my understanding is what a same or similar
20 individual would do in the same or similar
21 circumstances.

22 Q **(By Ms. Irene, continuing) And what is a**
23 **differential diagnosis?**

24 A Well, I have an understanding of that based on my
25 nursing education. I do not provide differential

1 diagnosis. That's outside of my scope.

2 So I can provide you with my understanding
3 of the definition of differential diagnosis based
4 on my years in nursing if you would like me to
5 provide that, but it's outside of my scope.

6 **Q Okay. Yes. Could you provide me with your**
7 **understanding of what a differential diagnosis is**
8 **from your experience as a nurse.**

9 **A** So a differential diagnosis is the various
10 conditions that a physician, nurse practitioner,
11 physician assistant, may be considering in terms
12 of diagnosing a patient. There may be -- they
13 may have symptoms that are reflective of numerous
14 conditions.

15 And so they, more often than not, they'll
16 list all of those things in their differential
17 diagnosis saying we're going to try to rule this
18 out, rule that out, rule this out until we get to
19 a final diagnosis.

20 **Q And what is your understanding of why**
21 **differential -- or I'm sorry, are differential**
22 **diagnoses important?**

23 **A** This is outside my scope at this point.

24 **Q Okay. So you're saying that you don't have an**
25 **understanding of why differential diagnoses are**

1 **important?**

2 MR. KNOTT: I think she explained the
3 scope of her nursing practice. It's outside
4 the scope of her opinions in the case. And
5 it's also an incomplete hypothetical so that
6 someone trained in differential diagnosis
7 would have a hard time answering. But I
8 guess --

9 A Yes, I'm not -- I'm not trained in -- in
10 providing differential diagnosis. I, of course,
11 as a nurse will read that in hospital records or
12 emergency department records.

13 And I understand that the provider -- and
14 when I say "provider" going here forward, I'm
15 talking about a physician, a nurse practitioner,
16 or a physician assistant, people who diagnose and
17 prescribe -- that they utilize differential
18 diagnosis, I read that and know that they're
19 looking at these various things trying to get to
20 their final conclusion.

21 That's the extent of my -- I don't have any
22 training in providing differential diagnoses.

23 Q **(By Ms. Irene, continuing) Okay. Thank you for**
24 **that, Ms. Pearson.**

25 MS. IRENE: And, Mr. Knott, I'd just

ask, I'd appreciate no speaking objections in the future.

Q (By Ms. Irene, continuing) Ms. Pearson, are you aware of, do you know what an "anchoring bias" is?

A I cannot provide you with a definition of that as I sit here right now, no. I may have read about that in the past, but it's not anything I can come up with a definition for right now.

Q And are you aware of or do you know what "premature closure" is?

A I don't even know what that's --

MR. KNOTT: Objection. Vague.

A I don't know what that's in reference to.

Q (By Ms. Irene, continuing) Do you know the difference between a nurse and a nurse practitioner?

A Yes.

Q What is the difference between a nurse and a nurse practitioner?

MR. KNOTT: Object to the form of the question. It's vague. But go ahead.

A Well, at a very basic level, a nurse practitioner has additional education beyond that of a registered nurse and is by education, training,

1 and licensure able to diagnose and prescribe
2 medication, whereas a registered nurse cannot.

3 Q (By Ms. Irene, continuing) Would you agree with
4 me that a nurse serves as the eyes and ears of a
5 medical team?

6 MR. KNOTT: Object to the form of the
7 question. It's vague.

8 A No, I wouldn't word it that way. I -- a
9 registered nurse gathers information and provides
10 information as clinically necessary to
11 higher-level providers when clinically
12 necessary.

13 Q (By Ms. Irene, continuing) Have you ever heard
14 the phrase that "nurses are the vanguard", the
15 vanguard for observing changes in a patient's
16 system -- or symptoms?

17 A No, I've never heard that phrase.

18 Q And would you agree that nurses act as a sort of
19 hub of communication between physicians or
20 practitioners and patients and their families?

21 MR. KNOTT: Object to the form of the
22 question.

23 A No, I wouldn't agree. It depends on the setting.
24 It depends -- it depends on the circumstances.

25 Q (By Ms. Irene, continuing) So can you say more

1 **why don't you agree with that?**

2 A Well, just one of many issues. One example would
3 be, as you worded it, nurses in jail settings
4 aren't routinely calling families, whereas that
5 may be more common in another setting. So I
6 just -- I can't agree with how you worded it.

7 Q **Okay. Sure. So I guess I'll take out the**
8 **families.**

9 Would you agree that nurses act as a sort of
10 hub of communication between physicians and
11 patients?

12 MR. KNOTT: Object to the form of the
13 question. Vague. And vague as to
14 circumstance.

15 A No, I wouldn't agree. I wouldn't call them a
16 hub. I would say exactly what I said I think the
17 previous couple of answers ago, that nurses do
18 provide information -- clinically relevant
19 information to a higher-level provider when it's
20 clinically necessary and justified. So there is
21 that communication that does occur.

22 Q **(By Ms. Irene, continuing) Are nurses a main**
23 **source of information for physicians about**
24 **getting information for patients?**

25 A It depends on the setting.

1 MR. KNOTT: Objection.

2 Q (By Ms. Irene, continuing) Would you agree that
3 effective communication in nursing is important
4 for providing the best and safest possible care?

5 MR. KNOTT: Object to the form of the
6 question.

7 A Could you repeat, please.

8 Q (By Ms. Irene, continuing) Would you agree that
9 effective communication in nursing is important
10 for providing the best and safest patient care
11 possible?

12 A I think communication is important when it's
13 clinically necessary.

14 Q And would you agree that clear, accurate, and
15 accessible documentation is an essential element
16 of safe, quality, evidence-based nursing?

17 MR. KNOTT: Object to the form of the
18 question. It's vague and overly broad.

19 A I -- yes. No, I wouldn't agree to how that was
20 phrased at all. No.

21 Q (By Ms. Irene, continuing) Okay. Why don't you
22 agree?

23 A Could you repeat all of your qualifiers, please.

24 Q Yeah. Would you agree that clear, accurate, and
25 accessible documentation is an essential element

1 **of safe, quality, evidence-based nursing?**

2 MR. KNOTT: Object to the form of the
3 question. It's vague. Overly broad.

4 A Yeah, again, it depends on -- it depends on the
5 situation.

6 Q **(By Ms. Irene, continuing) When would you not**
7 **want documentation to be clear, accurate, and**
8 **accessible?**

9 MR. KNOTT: Object to the form of the
10 question. It's vague and overly broad.

11 A Well, it's not that I don't want that. It's
12 just, again, it depends on the situation.

13 For instance, I have certainly been a part
14 of a telehealth encounter where there's a
15 physician on the other side of the screen and I
16 am the nurse and with the patient. The physician
17 doesn't have my documentation in front of him.

18 So that's just one of many points that --
19 that's not accessible at that point, but it
20 doesn't mean that that interaction is not
21 appropriate. It certainly is.

22 Q **(By Ms. Irene, continuing) Yes, I guess I am**
23 **asking when there -- when there is documentation,**
24 **do you agree that's important that that**
25 **documentation be clear, accurate, and made**

1 **accessible?**

2 MR. KNOTT: Object to the form of the
3 question. It's vague and overly broad.

4 A I believe that documentation should be accurate
5 and I believe it should be maintained.

6 However, the system in question, and systems
7 do it differently, however they maintain their
8 patient records.

9 Q **(By Ms. Irene, continuing) Would you agree that**
10 **nurses are one of the primary people who are able**
11 **to observe a patient's signs and symptoms?**

12 A Well, that --

13 MR. KNOTT: Object to the form of the
14 question. It's vague and overly broad.

15 A That completely depends on the circumstances and
16 the venue.

17 Q **(By Ms. Irene, continuing) As a nurse are you**
18 **trained to catch changes in a patient's**
19 **condition?**

20 A Nurses are trained to observe.

21 Q **And what are nurses trained to observe?**

22 A Nurses are trained to consider the subjective
23 information they receive from a patient and then
24 make their observations to determine whether the
25 subjective and the objective information seems

1 accurate. So it depends on the situation, what
2 they're observing.

3 If someone comes into the emergency
4 department and they think they have a broken
5 finger, we're observing their finger, not
6 necessarily looking at their feet.

7 **Q And are nurses trained to observe changes in**
8 **symptoms of patients?**

9 A Well, that -- that's a generality. Again, of
10 course, it depends on the situation.

11 **Q What are some of the situations where nurses**
12 **would be told to not observe changes of symptoms**
13 **in patients?**

14 MR. KNOTT: Object to the form of the
15 question. It's a vague and overly broad
16 hypothetical.

17 A Right. I would not characterize it as nurses
18 being told not to observe.

19 But as you've asked it, for instance, if I
20 walk by a patient that I've never seen before I
21 don't have any prior baseline, so I don't know if
22 there's been a change in that patient or not.

23 So again, it depends on the situation. You
24 know, are you a nurse that you have eight hours
25 assigned to one patient in a hospital. I'm

1 assuming when you're dedicating eight hours to
2 that one patient you might observe -- you would
3 likely observe changes.

4 But in a jail, as I'm walking by someone
5 that I've never seen before, I can't tell you if
6 they've had a change. I don't know anything
7 about them prior to my walking by. So it
8 depends --

9 Q (By Ms. Irene, continuing) Sure.

10 A -- on the situation.

11 Q Sure. So to clarify, are nurses trained to
12 observe symptom changes in patients that they
13 are -- have already had previous interactions
14 with or that they are assigned to?

15 MR. KNOTT: It's vague and overly
16 broad, but go ahead.

17 A Well, nurses are definitely trained to observe.
18 And if they notice clinically relevant changes,
19 then yes, they would report clinically relevant
20 changes.

21 Q (By Ms. Irene, continuing) In general, and I
22 understand that this may not be in every single
23 case, but in general do nurses see patients more
24 than physicians?

25 A Well, that completely depends on the venue.

1 Q Okay. In your experience, do nurses see patients
2 more than physicians?

3 A In 40 years, as we went through my CV, I've been
4 in so many venues, they're all completely
5 different. So again, it depends on the venue.

6 Q Okay. In correctional health care facilities, in
7 your experience, do nurses typically see patients
8 more than physicians?

9 A So that depends on the size of the facility and
10 how that's staffed.

11 Q Have you worked at facilities where physicians
12 see patients more than nurses?

13 A I don't know how to answer that question. I can
14 tell you that there are often more nurses on
15 staff than physicians in terms of that ratio.

16 Q Were you unaware at your previous correctional
17 health facility how often nurses as opposed to
18 physicians saw patients? Are you saying you
19 don't know?

20 A Am I unaware of what? Could you reask?

21 Q Of how often physicians and nurses saw
22 patients?

23 A I'm aware of how often nurses and physicians saw
24 patients, but I had 10 buildings and 7,000 people
25 and so I don't tally that. Again, there are more

1 nurses than there are physicians in my system.
2 Again, it depends on the particular facility and
3 how they've staffed it.

4 **Q Sure. But if you're aware of how often nurses**
5 **saw patients and how often physicians saw**
6 **patients, all I'm asking is if you're aware of if**
7 **nurses saw patients more than physicians?**

8 MR. KNOTT: Object to the form of the
9 question. It's vague, and it's asked and
10 answered.

11 **A** So I want to answer your question, I just
12 don't -- it's difficult as you have asked it in
13 that my physicians were seeing patients all day
14 long. Whereas my nurses, even though there were
15 more of them, may not have been seeing patients
16 all day long. Or they may have been grouped in
17 one area seeing all the intakes that were coming
18 in and not in the other nine housing units -- or
19 nine buildings. So it's hard for me to answer as
20 you've asked it.

21 Again, there are more nurses on staff in a
22 larger system than there are physicians, but it
23 still depends on the size of the facility and how
24 they've chosen to staff it.

25 **Q (By Ms. Irene, continuing) Okay. So as I've**

1 asked it, it's your -- you're unaware of in the
2 correctional facilities that you oversaw who saw
3 patients more, nurses or physicians?

4 A No, I'm not unaware.

5 MR. KNOTT: Object to the form of the
6 question. It's argumentative. Asked and
7 answered.

8 Go ahead.

9 A I'm not unaware. I'll repeat it. There are more
10 nurses, there were more nurses in my system than
11 physicians. But you're asking me numbers, and my
12 physicians were seeing patients all day long.
13 And there were times when nurses were not, but I
14 had more nurses. So --

15 Q (By Ms. Irene, continuing) Yes, I understand that
16 there were more nurses. And you're right, I'm
17 not asking about if there were more nurses.

18 I'm asking if you know who had more frequent
19 contact with patients, nurses or physicians, or
20 do you not know?

21 A It completely depended upon the patient. There
22 were some patients that saw physicians more
23 frequently than nursing staff, and some who saw
24 nursing staff more frequently than physicians,
25 and some who didn't see anybody because they had

1 no medical needs.

2 **Q Okay. So there was no trend?**

3 A Trend, no. Again, there are more nurses than
4 there are physicians.

5 **Q Is it part of making sure a patient is safe and**
6 **receiving adequate care that nurses be good**
7 **listeners?**

8 A Could you repeat the question, please.

9 **Q Is it part of making sure a patient is safe and**
10 **receiving adequate care that nurses are good**
11 **listeners?**

12 A Nurses are trained in the provision of care to be
13 a good listener.

14 **Q And why are they trained to do that?**

15 A Well, back to the subjective and objective
16 information, that's what nurses are trained to do
17 is to gather subjective, which means listening to
18 what the patient says. And then also observing
19 other information about the patient.

20 **Q And would you agree that it's important for**
21 **nurses to be good listeners?**

22 A It's important for nurses to gather subjective
23 information. So to hear what the patient's
24 saying, I guess you could say they need to
25 listen.

1 Q And would you agree that this is important
2 because if nurses are not listening closely to
3 gather that subjective information, there could
4 be dangerous or harmful consequences?

5 MR. KNOTT: I'll object. It's vague
6 and overbroad.

7 A No. I'm sorry. Go ahead.

8 MR. KNOTT: I was objecting that it's
9 vague and overly broad. Sorry to interrupt.

10 A No. Nurses are obtaining subjective information,
11 and only the subjective information provided to
12 them, so you can't tie the two together. And a
13 patient may not be forthcoming and may not tell
14 the nurse everything.

15 That's certainly not -- that doesn't go down
16 a trail of the nurse didn't do his or her job or
17 didn't do it well. They're only able to take in
18 the subjective information the patient offers.

19 Q (By Ms. Irene, continuing) So to be clear,
20 Ms. Pearson, I'm asking about the subjective
21 information that the patient offers.

22 Would you agree that if a nurse does not do
23 a good job taking down that subjective
24 information that the patient offers, that it can
25 lead to harmful or dangerous consequences?

1 A Well, it depends on the situation. It depends on
2 the situation.

3 Q One -- one moment.

4 MR. KNOTT: Madison, if we get to a
5 breaking point, we've been going at it about
6 an hour and 15 minutes.

7 MS. IRENE: Yes, I only have a few more
8 questions sort of left in this section, so I
9 think we should be coming up on one soon.

10 Q (By Ms. Irene, continuing) But, Ms. Pearson, I
11 just want to follow up.

12 So in what situation would a nurse not
13 accurately taking down the information that's
14 being told to them not potentially lead to
15 harmful or dangerous consequences?

16 MR. KNOTT: Object. It's vague and
17 overly broad.

18 A So let me give you an example. If a patient said
19 I'm diabetic and I need insulin, and the nurse
20 said yeah, yeah, yeah, and turned around and
21 walked away, that would be a serious consequence.

22 On the other hand, if a nurse -- or a
23 patient said I need 10 Band-Aids for my foot, I
24 keep these Band-Aids on my foot, and the nurse
25 didn't necessarily write that entire conversation

1 in their note and it really had -- it wasn't a
2 clinical medical issue, it was just something the
3 patient for whatever reason wanted to do, that
4 would not necessarily lead to a serious problem.

5 Again, it completely depends on the
6 scenario.

7 Q (By Ms. Irene, continuing) Okay. But,
8 Ms. Pearson, that's not what I'm asking. I'm not
9 asking if in every single situation that a nurse
10 doesn't write down the subjective information
11 that they're being told that it will lead to
12 harmful consequences.

13 What I'm asking is if a nurse does not
14 accurately write down the subjective information
15 they're being told to them, could it lead to
16 harmful or dangerous consequences for the
17 patient?

18 MR. KNOTT: I'm objecting to the form
19 of the question. You're getting
20 argumentative.

21 You asked her to list circumstances in
22 which it would not be harmful, so you were
23 asking her to explain every circumstance.

24 But I object to the form of the
25 question. It's vague, overly broad, and

1 asked and answered.

2 A So taking down subjective data consists of, in a
3 medical record, for the purposes of continuity,
4 is to record the clinically relevant information.

5 So when a patient comes in and says -- or
6 you say hi, how are you, and they say fine, we're
7 not writing that in the chart.

8 So again, it's clinically relevant data, as
9 in my example, if a patient provided information
10 about something and the nurse said oh, yeah,
11 whatever, and walked out of the room, that would
12 be a problem.

13 But nurses are trained to write down the
14 clinically relevant subjective information
15 provided by the patient.

16 Q **(By Ms. Irene, continuing) And if a nurse**
17 **incorrectly writes down or omits parts of the**
18 **clinically relevant subjective information, could**
19 **that lead to harmful and dangerous consequences**
20 **for the patient?**

21 MR. KNOTT: Object. It's vague.

22 Overly broad.

23 A If you'd like to use the example I gave you, that
24 potentially could be a harmful situation if a
25 nurse walked away and didn't write anything down.

1 Q (By Ms. Irene, continuing) But to be clear, even
2 if a nurse writes some things down but does not
3 write down all of the clinically relevant
4 subjective information that a patient provides,
5 it could lead to dangerous or harmful
6 consequences for the patient?

7 MR. KNOTT: Object to the form of the
8 question. Asked and answered. Vague and
9 overly broad.

10 A It depends. No, I would say that's not a --
11 that's just not a 100 percent statement at all.

12 Again, you have to understand that the
13 nursing process includes subjective and
14 objective, so it's a combination of the two.

15 Q (By Ms. Irene, continuing) Okay. Yes, I've been
16 saying subjective because that's what you've been
17 using. But to be clear, I'm asking about
18 subjective and objective information.

19 If a nurse fails to write down some of the
20 clinically relevant subjective and objective
21 information, could you --

22 A You've only been asking subjective. But --

23 Q Okay. So why is that difference important to
24 you? Why -- what is -- why is that difference
25 important to you?

1 A Well, it's very important. It's very important.

2 For example, again, the patient is going to
3 tell you what the patient chooses to tell you.
4 And they may be fully forthcoming and they may
5 not and they may be confused. I mean, there's
6 any number of scenarios.

7 And then the nurse uses objective
8 evaluation. We'll use this case. Ms. Boyer told
9 Nurse Fennigkoh that she -- I'm using her
10 words -- she was peeing as she was standing
11 there. That's her subjective.

12 The objective information that Nurse
13 Fennigkoh documented was that she was standing in
14 front of her, she had on, I don't know if it was
15 tight pants, yoga pants, some sort of formfitting
16 pants, and there was no urine noted. That's the
17 objective. So you have to consider both.

18 Q Okay. So in the future, if I'm asking you a
19 question that you feel like you can't answer or
20 I'm missing something important like that, I
21 would just ask that you let me know how the
22 question can be changed so that you can better
23 answer it. So I will ask you --

24 MR. KNOTT: That's an improper
25 instruction. You can't put that burden on

1 her. You have to ask the question and she'll
2 answer it.

3 Q (By Ms. Irene, continuing) Okay. So I'll ask you
4 now about objective information.

5 If a nurse omits clinically relevant
6 objective information, could that lead to --
7 could that lead to danger or harm for the
8 patient?

9 MR. KNOTT: Object to the form of the
10 question. It's vague and overly broad.

11 A Again, always depends on the situation and the
12 circumstances.

13 But yes, if the patient is unconscious on
14 the floor and the nurse walks away and does not
15 document that or take action, that would be
16 potentially harmful.

17 Q (By Ms. Irene, continuing) Okay. But what I'm
18 asking is not just in the situation where a
19 patient is passed out on the floor and a nurse
20 walks away.

21 I'm asking if in general, if a nurse omits
22 clinically relevant information, could that lead
23 to potential harm or danger for the patient?

24 MR. KNOTT: I need to object to the
25 form of the question. It's vague as to

1 circumstance. It's overly broad.

2 A Okay. As I understand you asked it, if the nurse
3 omits clinically relevant information, could that
4 be harmful?

5 Q **(By Ms. Irene, continuing) In short, yes.**

6 A Again, it depends, because there may be
7 clinically relevant information that the patient
8 has not provided. Therefore, a nurse cannot
9 document something that a nurse is unaware of.

10 Q **Okay. And if a nurse omits clinically relevant**
11 **information that a patient has provided, could**
12 **that lead to potential harm or danger for the**
13 **patient?**

14 MR. KNOTT: Object to the form of the
15 question. Vague and overly broad.

16 A Again, it depends on the situation. Potentially
17 it could be, but not in every case.

18 Q **(By Ms. Irene, continuing) Okay. And one of the**
19 **ways that nurses give information is through**
20 **documentation in medical records; is that**
21 **right?**

22 A Yes. Nurses document their patient care.

23 Q **And is one of the reasons why they do this in**
24 **order to make sure that a physician is aware of**
25 **all the information that they have received?**

1 MR. KNOTT: Object to the form.

2 A I would not describe it in that way. Nurses
3 document in the record because they have been
4 trained to do so for purposes of tracking what
5 has occurred with the patient clinically, and any
6 number of individuals may look at that record.
7 It's not specifically for a physician per se.
8 It's medical team.

9 Q (By Ms. Irene, continuing) Okay. And do nurses
10 rely on physicians reading the documentation that
11 they have put in the medical record?

12 MR. KNOTT: Form, vague, and overly
13 broad.

14 A That would depend nurse to nurse to doctor to
15 doctor to venue. That depends.

16 Q (By Ms. Irene, continuing) So you're saying there
17 is venues where it would not be important for the
18 physician to read the documentation that nurses
19 put in the medical record?

20 A No, that's not -- that's not what I said. You
21 asked if it was -- that nurses -- I don't recall
22 exactly how you asked it, but expected the
23 physician to look at it, something to that. And
24 no, that's not always the situation.

25 The example I gave you for telehealth, that

1 physician on the other side of the screen may not
2 see that nurse's documentation. That's a verbal
3 discussion and observation working with the
4 patient over the screen. The nurse is not
5 expecting the doctor to ask for her nurse's note
6 to send it over necessarily.

7 So there are definitely venues and
8 situations where that's not the case.

9 MS. IRENE: Okay. I think now would
10 probably be a good time to take a break.

11 MR. KNOTT: Sure.

12 THE VIDEOGRAPHER: All right. We're
13 off the record at 11:25.

14 (Off the record)

15 THE VIDEOGRAPHER: We are back on the
16 record for the deposition of Kim Pearson
17 being conducted by videoconference. Today is
18 February 26, 2025, and it is 11:32 a.m.
19 Central.

20 Q (By Ms. Irene, continuing) Ms. Pearson, did you
21 form an opinion in this case about the standard
22 of care provided by Nurse Fennigkoh?

23 A Yes.

24 Q Did you form an opinion in this case about the
25 standard of care provided by ACH?

1 MR. KNOTT: Object. It's vague and
2 overly broad.

3 A Yes, in that the service -- their services are
4 reflected in Nurse Fennigkoh's care and
5 actions.

6 Q (By Ms. Irene, continuing) Did you form an
7 opinion in this case about the standard of care
8 provided by ACH outside of Nurse Fennigkoh's
9 actions -- Nurse Fennigkoh's care and actions?

10 MR. KNOTT: I think that's vague and
11 overly broad.

12 A Well, I don't know how to separate the two.
13 She's employed by ACH, so.

14 Q (By Ms. Irene, continuing) I guess what I'm
15 asking is, did you form an opinion in this case
16 about the standard of care provided by ACH in
17 anyone else's cares and actions?

18 For example, in Nurse Pisney's care and
19 actions?

20 A No, I was not --

21 MR. KNOTT: Object. Vague. But if you
22 want to answer the question with respect to
23 Ms. Pisney, go ahead.

24 A I was not asked to review this matter related to
25 Nurse Pisney.

1 Q (By Ms. Irene, continuing) Do you know when
2 Ms. Boyer was initially booked in the Monroe
3 County Jail?

4 A Yes.

5 Q And when was she booked?

6 A December 21st of 2019.

7 Q And can I ask, I see you looking down slightly,
8 are you looking at a document?

9 A My report.

10 Q Okay. Just because I'm not there with you, in
11 the future, if you are looking at a document to
12 help answer a question, if you could let me know
13 what document you're looking at, that would be --

14 A I guess I have to refer to my report because I
15 don't have all of the dates and times
16 memorized.

17 Q Oh, yes. No, of course. Refer to your report.
18 It's just because we're not in person --

19 A Sure.

20 Q -- otherwise I'd be able to see what you're
21 looking at, and then I could look at it too.
22 Just let -- yes. So if you -- I understand you
23 have your report in front of you now. If you
24 switch off or start looking at something else, if
25 you could just let me know.

1 A No problem.

2 MR. KNOTT: So just so I'm clear, you
3 want her to tell you if she's looking at
4 something other than her report?

5 MS. IRENE: Yes. If she's -- if she's
6 looking at another document or something
7 that's in front of her that she's using to
8 rely upon to give her answers.

9 MR. KNOTT: Okay. Because I don't want
10 her to interrupt her answer every time she
11 looks down in order to let you know, so.

12 Q (By Ms. Irene, continuing) Yes. To be clear, you
13 do not -- I understand that you're looking at
14 your report. You do not need to say every time
15 I'm looking at my report. Just if you move on to
16 something, some other different document other
17 than your report.

18 A Okay.

19 Q Who was the medical professional who first
20 interacted with Ms. Boyer?

21 A Based on my review of the records it would be RN
22 Fennigkoh.

23 Q And what was Nurse Fennigkoh's interactions with
24 Ms. Boyer -- or first interaction with
25 Ms. Boyer?

1 A Well, when she came into the jail.

2 Q Did Nurse Fennigkoh do an intake screening for
3 Ms. Boyer?

4 A No, she did not do the intake screening document.
5 That's done by custody. So she interviewed
6 Ms. Boyer and wrote a nurse's note.

7 Q And during Nurse Fennigkoh's interview with
8 Ms. Boyer, what did Ms. Boyer say?

9 MR. KNOTT: Object. It's vague and
10 overly broad.

11 A Well, we would need to pull up the note. It's --
12 she -- RN Fennigkoh wrote what Ms. Boyer said. I
13 can't tell you verbatim without looking at it.

14 Q (By Ms. Irene, continuing) Sure. One moment.
15 Sorry, I'm just going to share my screen.

16 MR. KNOTT: I think it's Exhibit 6.

17 MS. IRENE: Yes, I think.

18 Q (By Ms. Irene, continuing) Ms. Pearson, is this
19 the note that you're referring to?

20 A Yes.

21 Q So is this the narrative note?

22 A Yes. I'm sorry, I probably called it a nursing
23 note, but it's a narrative note.

24 Q I'll mark this as Plaintiff's Exhibit 4.

25 MR. KNOTT: Previously marked as

Exhibit 6.

MS. IRENE: Thank you.

Q (By Ms. Irene, continuing) So during Ms. -- or Nurse Fennigkoh's interview with Ms. Boyer, was Nurse Fennigkoh informed by a corrections staff officer that Ms. Boyer was a medical mess?

A I -- that's not my understanding based on what's written. There was a Tomah PD officer who made that statement, not a correctional officer, according to the note.

Q Yes, thank you. And what did -- what were some of the medical concerns that Ms. Boyer relayed to Nurse Fennigkoh?

A Do you want me just to read it to you?

Q Sure.

A Okay. So Nurse Fennigkoh wrote, patient states I only have one year to live. Nurse Fennigkoh asked for further clarification. Ms. Boyer stated, in quotes, I have all my organs shutting down. Radiation back then did me in. I don't have a hip. I pee myself and shit myself every 20 minutes. I am peeing right now.

Additional questions were asked by Nurse Fennigkoh. Ms. Boyer stated, in quotes, what's it matter to you. Also stated I have had bone

1 cancer, blood cancer, three pelvic surgeries,
2 three bladder lifts, three abdominal surgeries,
3 do you want me to continue.

4 She also reported to -- she stated to Nurse
5 Fennigkoh, my husband doesn't know where my
6 medication is. I hide it from him. He doesn't
7 have a clue what I take. And she said she would
8 call him regarding the medications.

9 **Q Did Ms. Boyer say if she was on any**
10 **medications?**

11 A She indicated she was on a blood pressure med and
12 oxycodone and other meds, but did not
13 elaborate.

14 **Q On this narrative note where it says PT, do you**
15 **know what PT stands for?**

16 A Patient.

17 **Q And was Ms. Boyer intoxicated at the time of this**
18 **interview?**

19 A Yes, that is my understanding.

20 **Q What is PBT?**

21 A PBT?

22 **Q Yes.**

23 A I believe -- I can't tell you what the letters
24 are. I believe that's the test that custody uses
25 to determine blood alcohol level. It's a

1 custody --

2 **Q Oh, I'm sorry. Were you finished?**

3 A Yeah, just custody test. It's not something
4 medical is involved in.

5 **Q And was Ms. Boyer's blood alcohol level .133?**

6 A Well, that's what's documented.

7 **Q And is that a high blood alcohol level?**

8 A Well, I don't know Wisconsin's number. I'm
9 assuming since -- it's not -- how would I answer
10 that. I mean, she's in the jail, and but it does
11 not reach the level of blood alcohol high enough
12 that she needs to be sent out to the hospital.

13 **Q Okay. And did Ms. Boyer say where she got her
14 medications in the interview?**

15 A Yes, she did. Tomah Medicine Shoppe.

16 **Q And did Ms. Boyer have any medications on her?**

17 A She had some loose pills in her purse.

18 **Q And were those pills able to be identified?**

19 A Some of them.

20 **Q And what were the ones that were able to be
21 identified identified as?**

22 A I would need to look at the verification sheet as
23 to which ones were identified. They were not all
24 identifiable.

25 **Q In her narrative report -- or narrative note did**

1 Nurse Fennigkoh write what medications she found
2 on Ms. Boyer?

3 A Yeah. Actually, she did. She wrote ondansetron,
4 aspirin, oxycodone, and other identified --
5 broken unidentified pills were found.

6 Q What is ondansetron?

7 A I believe that's Zofran for nausea.

8 Q One moment. Ms. Pearson, do you know what this
9 is?

10 A Intake medical screening report.

11 Q Is it the intake medical screening report for
12 Christine Boyer?

13 A Yes.

14 Q Did you review this?

15 A Yes.

16 Q At her intake screening did Ms. Boyer state that
17 she had one year to live?

18 A They quoted her here as saying some doctors say I
19 have a year to live.

20 Q And at the top of this --

21 MR. KNOTT: For the record -- I'm sorry
22 to interrupt. But for the record, the intake
23 medical screening is Exhibit 3 to the case,
24 just for the record.

25 MS. IRENE: Yes, thanks. And I guess

1 I'll mark this Plaintiff's Exhibit 5 for this
2 deposition.

3 MR. KNOTT: You actually don't need to,
4 but -- and we were also going in sequence.
5 We could try to sort that out at a break, but
6 just keep going. Do whatever you want to do,
7 Madison. I'm sorry.

8 MS. IRENE: No, thanks. That's
9 helpful.

10 Q (By Ms. Irene, continuing) And, Ms. Pearson, at
11 the top of this form where it says PBT per, we
12 said PBT and then it says -- sorry, I'll withdraw
13 that question.

14 Ms. Pearson, at the top of this form it says
15 PBT .133. That is blood alcohol content;
16 right?

17 A Yes. That's my understanding.

18 Q And then next to PBT .133 it says per and then
19 the numbers 1294.

20 Do you know what those numbers 1294 mean?

21 A I do not definitively know, but I will tell you
22 in my experience working in correctional settings
23 that officers typically sign with their assigned
24 number versus a name. So it -- that would be
25 logical to me, but I can't unequivocally tell you

1 that.

2 **Q Did Ms. Boyer stay -- or say in her intake**
3 **screening if she had taken blood medication that**
4 **day?**

5 **A If she had taken what?**

6 **Q Blood pressure medication that day?**

7 **A Oh, yes. It's written that she did take it that**
8 **day.**

9 **Q And was Ms. Boyer on any type of special diet?**

10 **A When she was asked that question she said**
11 **whatever I can keep down. Also said she was --**
12 **could not have peanuts or seeds due to her**
13 **bowel.**

14 **Q And is it your opinion that Ms. Boyer's**
15 **intoxication made it difficult for her to answer**
16 **questions about her medical history?**

17 **A Is it my, did you say opinion or impression?**
18 **Could you restate the question or reask the**
19 **question?**

20 **Q Yes. Sure. I asked for your opinion, but it**
21 **could also be your impression, that Ms. Boyer's**
22 **intoxication made it difficult for her to answer**
23 **questions about her medical history.**

24 **A Well, based on the note that RN Fennigkoh wrote,**
25 **she definitely was not forthcoming, often**

1 wouldn't answer, it was difficult to get
2 information.

3 And I believe that was -- Sergeant Warren I
4 believe had testified in her deposition of that
5 fact as well, that it was difficult to get good
6 information, get her to answer questions.

7 Q And on page 9 of your report, we had in this
8 deposition I believe previously marked this as
9 Plaintiff's Exhibit 3, sort of in the middle of
10 page 9, do you say that it's often challenging to
11 obtain a clear and accurate medical history from
12 intoxicated individuals newly booked into any
13 jail facility.

14 A Yes. I wrote that.

15 Q Can you tell me more about your experiences with
16 that. I'll withdraw. I can clarify.

17 Can you tell me more about in your
18 experiences the difficulties that you've had with
19 taking intake from intoxicated individuals who
20 are newly booked into a jail facility.

21 A Sure. It's, as I said, it's challenging, often
22 challenging to obtain clear and accurate medical
23 information. You get vague information. You get
24 partial information, incomplete information. And
25 oftentimes people are -- they don't want to

1 cooperate and so they just won't answer
2 questions. I mean, it varies.

3 It's about 69 to 70 percent of the
4 individuals coming in county jails have one or
5 more substance use issues, and so this is a very
6 prevalent population in the jails that we're
7 accustomed to working with. And it's just --
8 it's just known that it's -- it's difficult at
9 times when someone's intoxicated to get those
10 answers and you -- you just have to keep that in
11 mind.

12 **Q Would Ms. Boyer's blood alcohol content have been**
13 **lower by the following morning?**

14 **A** That's outside of my scope of expertise.

15 **Q You agree that someone is more likely to be able**
16 **to accurately relay information when they are**
17 **sober than when they are under the influence of**
18 **drugs or alcohol?**

19 **A** That's quite possible, yes.

20 **Q Is there any situation that you believe that not**
21 **to be true?**

22 **A** Well, you know, again, it depends on the
23 individual. Theoretically, you should be able to
24 get clearer, more accurate information if they're
25 not intoxicated. But you're also then, what else

1 is going on. Do they have a medical issue. Do
2 they have a mental health issue. Do they just
3 not want to cooperate. I mean, there's all kinds
4 of scenarios there, but.

5 **Q Okay. So to clarify, holding all other factors**
6 **constant, do you agree that it's more likely to**
7 **be able to accurately -- or accurately relay**
8 **information when patients are sober than if they**
9 **are under the influence of drugs or alcohol?**

10 **A** I think it's more likely. It's not a given.
11 Because again, you're dealing with patients --
12 I've dealt with hundreds and hundreds of patients
13 who could not relay their history to me clearly.
14 Didn't even know, you know, I'm on a blue pill.
15 I'm on a white pill. So it really depends on the
16 individual.

17 But yes, in theory, if you're not
18 intoxicated you would like to think that perhaps
19 you would get better, clearer information.

20 **Q So do you have experiences with patients who are**
21 **able to better relay information to you while**
22 **they were under the influence of drugs or alcohol**
23 **than when they were sober?**

24 **A** I don't know that I can come up with any examples
25 of that.

1 Q Do you have any experiences that you remember
2 personally with patients who were better able to
3 relay information to you when they were on drugs
4 or alcohol than when they were sober?

5 A Yeah, I can't think of any situations off the top
6 of my head.

7 Q Do you agree that it would have been possible for
8 Nurse Pisney to get another medical history from
9 Ms. Boyd (sic) the following day?

10 MR. KNOTT: Object to the form of the
11 question.

12 A I did not review this case in terms of Nurse
13 Practitioner Pisney.

14 Q (By Ms. Irene, continuing) Okay. Do you agree
15 that it would have been possible for Nurse
16 Fennigkoh to get another medical history from
17 Ms. Boyd the following day?

18 MR. KNOTT: Object to the form of the
19 question.

20 A Well, Nurse Fennigkoh wasn't on duty the
21 following day.

22 Q (By Ms. Irene, continuing) Was Nurse Fennigkoh at
23 the jail the following day on Sunday,
24 December 22nd?

25 A Yes, she was there late in the afternoon for a

1 one-patient assignment, not in her role as an ACH
2 nurse providing the care she typically provided
3 with ACH on a regularly scheduled day.

4 **Q I understand that, Ms. Pearson, but would it have**
5 **been possible for Nurse Fennigkoh to get another**
6 **history from Ms. Boyd while she was there the**
7 **following day?**

8 MR. KNOTT: Object to the form of the
9 question. It's asked and answered. Vague
10 and overly broad.

11 **A** Well, it's just not even -- it's not even
12 relevant. The intake screening was done by
13 custody on Saturday night, Saturday night/Sunday
14 morning.

15 And Nurse Fennigkoh -- there would not have
16 been any reason for Nurse Fennigkoh to act
17 outside of the scope of what she was there to do
18 that particular day to do that.

19 **Q (By Ms. Irene, continuing) Ms. Pearson, I**
20 **think -- I understand that you don't believe it**
21 **to be relevant, and I understand that you do not**
22 **think that there was a reason for Nurse Fennigkoh**
23 **to do so.**

24 But what I'm asking you is if you -- is if
25 it was possible for Nurse Fennigkoh to speak to

1 **Ms. Boyer again about her medical history on that**
2 **day?**

3 MR. KNOTT: Object. Asked and
4 answered. Foundation. Calls for
5 speculation. Vague and overly broad.

6 A It just is not part of the process that's in
7 place. Intake screening is done at the time of
8 intake. That's one component of correctional
9 health care, and then we move forward and there
10 are other avenues to get further information.

11 Intake screening is a snapshot at that point
12 when they come in to identify urgent and emergent
13 issues. So it's not part of -- it just is not
14 something that would be done. It's not standard
15 of care by any means to go back and do an intake
16 screening at that point.

17 Q **(By Ms. Irene, continuing) Ms. Pearson, I'm**
18 **sorry, but I have to ask you this question again.**
19 **I'm not asking if it was part of the process.**
20 **I'm not asking if you believe it was standard of**
21 **care. I'm asking -- I'm asking you if it was**
22 **possible for Nurse Fennigkoh to do so?**

23 MR. KNOTT: Object to the form of the
24 question. It's vague and overly broad.

25 A I don't know. I don't have an answer.

1 Q (By Ms. Irene, continuing) What information to
2 that question would have helped you to be able to
3 answer this question?

4 MR. KNOTT: It's vague. Overly broad.

5 A Well, it just -- it doesn't make sense. It's,
6 again, the intake screening is at intake, and
7 then there's other healthcare that follows. And
8 so -- this is the flow in any jail. Then
9 additional information is gathered. Not in an
10 intake screening. And as in this case,
11 additional information is gathered, discussions
12 with the nurse practitioner. That's just the
13 flow.

14 It's just not -- you don't go backwards.
15 And it's like at a hospital. You don't go
16 re-admit someone 24 hours later. They're already
17 admitted. You keep moving forward in gathering
18 information.

19 Q (By Ms. Irene, continuing) Okay. Do you agree,
20 based off the variety of things that Ms. Boyer
21 said about her health conditions during her
22 interview with Nurse Fennigkoh and during her
23 intake screening, that she could have had any
24 number of different medical conditions?

25 MR. KNOTT: Object to the form of the

1 question.

2 A She could have had medical conditions she did not
3 disclose, and then she stated several things that
4 she had undergone in her lifetime.

5 Q (By Ms. Irene, continuing) Do you agree that even
6 with the things she did disclose that she wasn't
7 specifically clear in what her conditions were?

8 A Yes. I mean, she wouldn't answer all of the
9 questions fully. And you never know if a patient
10 is fully forthcoming or not. You don't know.
11 You just have to take down the information -- the
12 information they provide, along with your
13 observations, and continue to move forward.

14 It's the same in the emergency department.
15 Patients come into the emergency department and
16 they tell you what they choose to tell you.
17 There's no way to know if they're fully telling
18 you everything about their condition.

19 Q And for Ms. Boyer, did a corrections officer
20 complete Ms. Boyer's intake medical screening?

21 A Yes. That's my understanding.

22 Q And are corrections officers trained medical
23 professionals?

24 A In general I would say no. There are some that
25 are. But in general, no.

1 Q Are intake screenings an important step in
2 patient care?

3 MR. KNOTT: Form. It's vague.

4 A Yes. Intake screening is the first step when
5 someone arrives at the jail to try to identify if
6 they have any emergent or urgent needs in terms
7 of their healthcare.

8 Q (By Ms. Irene, continuing) Sorry. I just want
9 to -- I just want to be clear. You said that
10 intake screenings are the first step.

11 I'm asking if you believe intake screenings
12 are an important step to patient care?

13 MR. KNOTT: Vague and overly broad.

14 A Yes. It's information that we desire to have
15 when someone comes into a jail.

16 Q (By Ms. Irene, continuing) And why is it
17 information that you desire to have?

18 A Well, again, the point of the intake screening is
19 to identify any emergent or urgent medical needs
20 that the patient may have as well as identifying
21 other healthcare issues that need perhaps further
22 investigation, more information. And we're also
23 wanting to make sure we don't have someone with a
24 contagious disease. That helps us figure out
25 where to house those people.

1 Q At her intake screening did Ms. Boyer report
2 having congestive heart failure?

3 A Not to Nurse Fennigkoh. But I believe -- I'd
4 have to see the intake screening form again. But
5 not to Nurse Fennigkoh.

6 Q One moment. Okay, Ms. Pearson. I'm just going
7 to reask the question.

8 At her intake interview, did Ms. Boyer
9 report having congestive heart failure?

10 MR. KNOTT: Object to the form of the
11 question. It's vague.

12 A It's -- I'm sorry.

13 Q (By Ms. Irene, continuing) You can answer,
14 Ms. Pearson.

15 A It's documented that she stated she had
16 congestive heart failure to the officer.

17 Q And did she say that she had health problems from
18 chemo and radiation?

19 A It's documented that she stated she had medical
20 issues due to chemo and radiation.

21 Q And did she report having asthma?

22 MR. KNOTT: Object to the form of the
23 question.

24 A Could you scroll up, please, one page.

25 Q (By Ms. Irene, continuing) Yes.

1 A It is circled that she reported having asthma.

2 Q Was Nurse Fennigkoh aware that there would be no
3 medical staff left to provide care for Ms. Boyer
4 after she left?

5 MR. KNOTT: Vague.

6 A Well, I believe Nurse Fennigkoh was aware that
7 there was not a nurse coming in for the overnight
8 shift.

9 However, there was healthcare available in
10 that the nurse practitioner was available 24/7 on
11 call. And Nurse Fennigkoh further directed
12 custody to contact the nurse practitioner, as
13 they would. This was a process they had in
14 place.

15 Q (By Ms. Irene, continuing) So after Nurse
16 Fennigkoh left, ended her shift, there was no
17 other medical care professional on site at the
18 jail?

19 A I -- yes, I believe that's accurate. There was
20 not a nurse following her. It was the 24/7
21 on-call provider available.

22 Q Did Nurse Fennigkoh give Ms. Boyd medical
23 clearance?

24 A Could you restate that in a different way?

25 Q Sure. Did Nurse Fennigkoh give Ms. Boyd medical

1 clearance for a physical assessment to be done by
2 a practitioner?

3 MR. KNOTT: Object to the form of the
4 question. I think it's vague.

5 A Well, nurses -- I can't answer -- no, because
6 nurses don't give medical clearance to allow a
7 practitioner to evaluate. That's -- it's not
8 a --

9 Q (By Ms. Irene, continuing) Sorry, were you
10 finished?

11 A Well, it's just not a -- that doesn't exist.

12 Q Okay. And did Nurse Fennigkoh recommend that
13 Ms. Boyer be taken to the hospital at any time?

14 MR. KNOTT: Recognize? Object to the
15 form of the question.

16 A No, I do not believe that she recommended her
17 going to the hospital if she did not have an
18 urgent or emergent need necessitating that.

19 Q (By Ms. Irene, continuing) Do you know if Nurse
20 Fennigkoh ever wrote down Ms. Boyer's vital
21 signs?

22 A I do not believe she did.

23 Q Do you know if Nurse Fennigkoh initiated a
24 withdrawal screening?

25 A No, she did not.

1 Q Can patients who have significant medical
2 conditions be affected by withdrawal differently?

3 MR. KNOTT: Object to the form of the
4 question. Foundation. Vague.

5 A That's outside my scope.

6 Q (By Ms. Irene, continuing) Looking at question
7 No. 3 on Ms. Boyer's intake medical screening the
8 question says, are you or will you be
9 experiencing alcohol or drug withdrawal?

10 Do you agree with me that this question asks
11 the patient to self-assess whether or not they
12 will be experiencing withdrawal?

13 A Yes, I agree with you in that -- two things. One
14 is, that is what an intake screening is. It's a
15 structured inquiry asked to the patient to get
16 information from the patient.

17 There are many, many people who cycle in and
18 out of jails who cycle on and off of drug use who
19 experience withdrawal, they know they're going to
20 experience withdrawal, they know what it feels
21 like, and that's pertinent information. Again,
22 that's the subjective component. And then we
23 have the objective -- the objective observations
24 that healthcare can look at as well.

25 So this is just one piece of information

1 that is very important for a patient. It's very
2 helpful, especially when a patient has had
3 withdrawal and they say yes, I've had withdrawal.
4 That's very important information for us.

5 **Q Are there patients who may not know if they're**
6 **going to experience withdrawal?**

7 **A Yes, there are.**

8 **Q And do you agree with me that this question does**
9 **not ask, for the patients who have experienced**
10 **withdrawal, what their withdrawal symptoms have**
11 **been in the past?**

12 MR. KNOTT: Madison, could you restate
13 that again?

14 MS. IRENE: Yes. Yes.

15 **Q (By Ms. Irene, continuing) Do you agree with me**
16 **that this question does not ask, for the patients**
17 **that have experienced withdrawal, that this**
18 **question does not ask what those withdrawal**
19 **experiences have been in the past?**

20 MR. KNOTT: Object to the form of the
21 question. It's beyond the scope of the
22 opinions. Foundation.

23 Go ahead.

24 **A Yes. The question is asking if they've**
25 **experienced -- are you currently or have you**

1 been, will you be experiencing withdrawal. It
2 doesn't go into the details of withdrawal.

3 **Q (By Ms. Irene, continuing) The question does not**
4 **ask about previous withdrawal symptoms?**

5 **A** Well, again, it's will you be experiencing, as I
6 described before. Because when people have
7 experienced withdrawal, they are likely to tell
8 you yes, I will be experiencing withdrawal based
9 on I have experienced withdrawal. I mean, that's
10 just logical.

11 **Q Yes, but are there different -- do people have**
12 **different withdrawal symptoms?**

13 **A** They do have different withdrawal symptoms.
14 However, those withdrawal symptoms in general
15 are, you know, there's 8, 9, 10, 11. It depends
16 on which substance we're talking about that are
17 the most common.

18 And so not everyone experiences --
19 everybody's withdrawal is different, and not
20 everyone experiences the same. And most people
21 don't even experience all of the most common.

22 **Q And does this question, question No. 3, ask**
23 **people to explain what their withdrawal -- their**
24 **previous withdrawal symptoms have been?**

25 **A** No. It's an intake screening. And so if they

1 answered yes, then as -- if a withdrawal
2 monitoring were going to be instituted, totally
3 separate piece of paper, totally separate issue,
4 then those things would be discussed at a
5 different time.

6 This is an intake screening. Snapshot in
7 time. We're trying to gather emergent/urgent
8 information.

9 **Q Do you agree that practitioners should be**
10 **conducting assessments to ascertain if a patient**
11 **is experiencing withdrawal symptoms?**

12 **A** Well, they asked her. She said no. There was no
13 observation of objective information that led --
14 would lead a reasonable clinical provider to
15 believe she was in withdrawal. So at this point
16 in time there's -- this has been answered.

17 As days, hours evolve, I mean, this is part
18 of -- if someone -- let me put it this way.
19 People come in and they say they're not using
20 drugs. And then two days later they contact
21 medical and say I'm in withdrawal and they didn't
22 report it to us at the time. So immediately at
23 that point we institute what needs to be done at
24 that point.

25 Withdrawal, these are just the first

1 questions at intake, and then it can expand from
2 there if it's clinically indicated.

3 **Q Aside from a patient saying that they are**
4 **experiencing withdrawal, what are indicators that**
5 **someone may experience withdrawal?**

6 MR. KNOTT: I think the question is
7 vague and overly broad. Could we specify
8 alcohol, drugs --

9 MS. IRENE: Yes.

10 MR. KNOTT: -- anything else and the
11 circumstance?

12 **Q (By Ms. Irene, continuing) Sure. Can increased**
13 **blood alcohol levels indicate a risk of**
14 **withdrawal?**

15 **A** Well, perhaps. But again, it depends on the
16 situation. Someone who goes out to a party and
17 gets intoxicated and comes in with a high blood
18 alcohol level but doesn't drink in general, that
19 blood alcohol level is not indicative of the fact
20 that they're going to go into withdrawal. That's
21 a one-time thing.

22 So again, it depends on the situation, it
23 depends on the patient, and their history.

24 **Q Yes. So, Ms. Pearson, to be clear, I'm not**
25 **asking if in every case increased blood level --**

1 if increased blood level -- sorry. Let me
2 withdraw that question.

3 Ms. Pearson, I'm not asking if in every case
4 increased blood alcohol levels are indicative of
5 withdrawal. I'm asking if increased blood
6 alcohol levels can be indicative of a risk for
7 withdrawal?

8 MR. KNOTT: Asked and answered and
9 vague, but go ahead.

10 A I don't think in and of itself that one number
11 alone would -- it depends. It depends. It
12 depends on how high that level is. Is this a
13 patient we know. Have they been in before. Have
14 we seen this before. There's so many
15 variables.

16 Q (By Ms. Irene, continuing) Okay. If a patient is
17 filling out an intake screening while
18 intoxicated, are their answers less likely to be
19 reliable than if they were sober?

20 A Okay. Well, patients don't fill out intake
21 screening forms. These are questions that are
22 asked by staff to the patient.

23 And if someone is intoxicated, and someone
24 who's not intoxicated, frankly, we're only going
25 to get as good of information as they are able

1 and willing to provide.

2 Q And when a patient is answering questions to an
3 intake screening form while intoxicated, are
4 their answers less likely to be reliable than if
5 they were sober?

6 A That's possible.

7 MR. KNOTT: Object. But go ahead.

8 A It's possible they may not provide as accurate or
9 clear of answers.

10 Q (By Ms. Irene, continuing) And looking at
11 question 13 on this form, do you abuse alcohol or
12 drugs, which kinds of alcohol or drugs and how
13 often do you use them, do you agree that this
14 question does not ask the patient if they know
15 what symptoms they have or may experience with
16 withdrawal?

17 A Well, no, it doesn't ask withdrawal questions.
18 It's not the withdrawal question. This is a
19 different question. This is just asking if they
20 abuse alcohol or drugs and what kind. The
21 withdrawal question was on the previous page.

22 Q In your opinion, are individuals who misuse
23 substances typically accurate in their
24 description of their pattern of substance
25 abuse?

1 A Well, I can't definitively answer that question
2 because only the patient's going to know. I
3 mean, if they say they use a half a gram of
4 heroin a day, that's what I would document. But
5 I don't -- I don't know that. They could be
6 completely accurate. I don't know.

7 Q Do you have experiences where patients over- or
8 underestimate their drug use?

9 A Well, again, I don't know, because I'm not with
10 them other than in that snapshot of time.

11 Q How does this intake screening compare to others
12 that you've seen in some of the places that
13 you've worked?

14 MR. KNOTT: It's vague and overly
15 broad.

16 A Well, intake screening reports -- intake medical
17 screening reports are -- they're all very
18 different in the order of questions.

19 But in terms of content, it does ask the
20 questions that we would expect -- we would want
21 to ask when an individual comes in at that point.

22 Q (By Ms. Irene, continuing) Is this intake medical
23 screening report less thorough than others that
24 you've seen?

25 MR. KNOTT: Vague and overly broad.

1 A No, I wouldn't say it's less thorough. Again,
2 it's different order. Different questions are
3 asked a little bit differently. But the content
4 and the intent of what we're trying to find out
5 is on the form.

6 Q (By Ms. Irene, continuing) One moment.

7 A I believe -- I believe I outlined all that in my
8 report in terms of what's required by NCCHC and
9 where it's found, on what question in the intake
10 screening.

11 Q You may have outlined. I may be asking you
12 questions about things that you have already said
13 in your report. But I just have to ask you them
14 sometimes just for my own clarification so I can
15 get a better understanding.

16 A Sure.

17 Q Okay. I'm going to share my screen with you
18 again. I'm now showing what's been Bates marked
19 Monroe County 000088.

20 Do you recognize this?

21 A Yes.

22 Q Did you review this?

23 A Yes.

24 Q Is this an email that was sent by Nurse
25 Fennigkoh?

1 A That's what it states, yes.

2 Q And was this email -- who was the email sent
3 to?

4 A Danielle Warren, Lucas Runice, Shasta Parker,
5 Kyle Moga, Ryan Hallman, and Stan Hendrickson.

6 Q And when was this email sent?

7 A December 22nd of 2019 at 6:02 p.m.

8 Q And what does this email say? Or I guess I'll
9 withdraw that question.

10 In this email does Nurse Fennigkoh convey
11 that Ms. Boyer's husband had called -- that she
12 had taken a call from Ms. Boyer's husband?

13 A Yes.

14 Q And on that call did Ms. Boyer's husband indicate
15 that he would be bringing medications for her?

16 A Yes.

17 Q And did Ms. Boyer take this call while she was at
18 the jail on Sunday, December 22nd?

19 A Yes.

20 Q And did she take it while she was there for --
21 while she was there for the purposes of seeing a
22 different patient?

23 A Yes and no. Yes, she was there to see the one
24 patient. And she had clocked out and yet took
25 this call because the phone rang after she had

1 clocked out and was getting ready to leave.

2 MR. KNOTT: For the record, that was
3 Exhibit 9 previously marked.

4 MS. IRENE: Thank you.

5 Q (By Ms. Irene, continuing) What happened after
6 Ms. Boyer completed her intake screening?

7 MR. KNOTT: Object to the form of the
8 question. It's vague and overly broad.

9 A In terms of what?

10 Q (By Ms. Irene, continuing) Sure. So what
11 happened -- do you remember Ms. Boyer complaining
12 to custody staff about feeling hot and sweaty?

13 A Okay. We're not talking about after -- we're on
14 a different topic now? Not after an intake
15 screening?

16 Q Oh, I'm asking, do you remember her saying that
17 she was hot and sweaty after the intake
18 screening?

19 MR. KNOTT: It's vague as to time.

20 A No, after the intake screening she was placed on
21 medical observation and monitored by officers all
22 night on Q 30 minutes or more checks, and there
23 were -- she had no concerns and no issues after
24 the intake screening over the course of the
25 night.

1 Q (By Ms. Irene, continuing) Ms. Pearson, if you
2 can look at -- hang on, I'll share my screen
3 again -- your report on page 10, and sort of the
4 middle of the page where you say at some point
5 prior to 4 p.m. Ms. Boyer had complained to
6 custody staff of feeling hot and sweaty,
7 difficulty breathing, and requesting that her
8 blood pressure be taken.

9 Are you referring to -- is that you
10 referring to Ms. Boyer at the intake screening?

11 A No. If you go back to page 9, the bottom
12 paragraph, this is a timeline chronology and
13 order of what happened. We're on Sunday,
14 12-22 --

15 Q Okay. So --

16 A -- at 4 p.m. So this is far beyond the intake
17 screening.

18 Q My apologies. Okay. So after the intake
19 screening Ms. Boyer did complain to custody staff
20 of feeling hot and sweaty?

21 MR. KNOTT: Object to the form of the
22 question. It's vague as to time. This is
23 asked and answered. And I think you need to
24 be specific as to a time frame.

25 A Yeah, the intake screening was on Saturday, the

1 21st, in the, you know, 11:30 time range. And
2 this is now Sunday, the 22nd, 4 p.m. So that's
3 what this note is about. It's not -- I mean,
4 it's sometime later. How many hours that would
5 be, 16 hours later.

6 Q (By Ms. Irene, continuing) Okay. So -- sorry.

7 Ms. Pearson, when you write in that
8 paragraph that at some point prior to 4 p.m.
9 Ms. Boyer had complained to custody staff of
10 feeling hot and sweaty, do you know what time she
11 made that complaint?

12 A Yes. I believe that was approximately around
13 3 p.m.

14 Q And was it around that time where Ms. Boyer also
15 complained of having difficulty breathing?

16 A There are some notes to that effect, and then
17 there's some -- yes, that she complained about
18 that, but Parker's deposition testimony stated
19 she didn't observe that. She didn't seem to have
20 any difficulty breathing.

21 Q And was it also around that time, 3 p.m., that
22 Ms. Boyer requested that her blood pressure be
23 taken?

24 A Yes. That's my understanding.

25 Q Was Ms. Boyer's oxygen saturation taken?

1 A I don't recall. I would need to look at the
2 records. I would need to look in the records.

3 Q Is -- what document in particular would you need
4 to look at?

5 A I don't know if it's -- I just don't recall if
6 it's documented on the illness reports or not.

7 Q Is oxygen saturation a vital sign?

8 A It can be considered a vital sign.

9 Q What is oxygen saturation?

10 A The saturation of oxygen in the blood.

11 Q And why could it be considered a vital sign?

12 MR. KNOTT: Object to the form of the
13 question.

14 A I'm not sure how to answer that question. It's
15 sometimes obtained with other vital signs.
16 Sometimes not. It's a piece of data.

17 Q (By Ms. Irene, continuing) Is it an important
18 piece of data?

19 MR. KNOTT: Object. Vague. Overly
20 broad.

21 A It depends on the situation.

22 Q (By Ms. Irene, continuing) Are vital signs
23 important pieces of data?

24 A Are they what?

25 Q Are vital signs important pieces of data?

1 A Yes, they can be. It depends on the situation.

2 Q Are there situations where vital signs are not
3 important pieces of data?

4 A So in healthcare we have some scenarios that we
5 call focused assessment. So rather than doing a
6 full head-to-toe history of someone's entire
7 medical life, let's use an example, I'm just
8 giving you an example of you're at a
9 half-marathon medical tent and somebody fell and
10 they've got an open fracture. Okay, they're
11 dealing with a fracture. It's a focused
12 assessment. They're dealing with the immediate
13 urgent issue at the time.

14 So vital -- vital signs are pieces of
15 information, absolutely, and they can be very,
16 very helpful. But they're not always obtained in
17 every -- every healthcare encounter because
18 they're not clinically necessary in every
19 clinical encounter.

20 Q Do you know if Ms. Boyer's respiratory rate was
21 taken?

22 MR. KNOTT: Form.

23 A I believe that -- I believe there was some
24 documentation by the officers on one of the
25 illness reports about a respiratory rate.

1 Q (By Ms. Irene, continuing) And just so I'm clear,
2 when you say "illness reports", what documents
3 are you referring to?

4 A I believe they're called illness reports. It's
5 the form that custody uses to document a
6 patient's healthcare concerns, and then as in
7 this situation made a call to Nurse Practitioner
8 Pisney and documented on that form about that
9 call.

10 Q Okay. One moment.

11 A Actually, I'd like to add to my previous answer
12 about oxygen saturation. I just was -- flipped
13 the page in my report, and I documented in my
14 report that her oxygen saturation had been taken,
15 so.

16 Q Okay. So to my question was Ms. Boyer's oxygen
17 saturation taken, your answer is now yes?

18 A It is, yes.

19 Q Actually, sorry. It's too late to withdraw that,
20 but let me just reask the question.

21 Was Ms. Boyer's oxygen saturation taken?

22 A Yes.

23 Q When was Ms. Boyer's oxygen saturation taken?

24 A Well, again, I would need to go back and look at
25 all the records. I'm just looking at one line

1 item in my report, and it was during the time
2 when custody staff completed the illness report
3 at 8:53 in the evening, and it's documented on
4 there. It may be other places as well. I just
5 don't recall without pulling up the records.

6 Q Was Ms. Boyer's heart rate taken?

7 A Yes.

8 Q Is heart rate a vital sign?

9 A Yes.

10 Q And, sorry, I'm going to share my screen again.

11 Ms. Pearson, I'm showing you the Medication
12 Administration Record for Ms. Boyer.

13 Have you seen this before?

14 A Yes.

15 Q Did you review this?

16 A Yes.

17 Q Is this one of the things that you were talking
18 about as being part of the illness report?

19 A No.

20 Q Okay. On Sunday, December 22nd, did Officer
21 Shasta Parker speak with Nurse Pisney?

22 MR. KNOTT: Form.

23 A I'm -- I just need to look at my report because I
24 don't even know if I wrote which officer spoke to
25 Nurse Pisney, but I may have written custody

1 called. I'm just not sure which one without
2 really going through my report and see if I even
3 noted that.

4 MR. KNOTT: Madison, are you referring
5 to Nurse Practitioner Pisney or Nurse
6 Fennigkoh?

7 MS. IRENE: I am asking about Nurse
8 Practitioner Pisney.

9 MR. KNOTT: Okay. Thank you.

10 **Q (By Ms. Irene, continuing) And yes, Ms. Pearson,**
11 **please take however long you need to look over**
12 **your report.**

13 **A** Well, again, I don't know that I would have
14 specified which officer called the nurse
15 practitioner. I know -- I know Parker was on
16 duty.

17 But again, if we want -- if we want to pull
18 up records, I can start to try to figure that
19 out. But I know Custody did contact Nurse
20 Practitioner Pisney, absolutely.

21 **Q And do you know why officers contacted Nurse**
22 **Practitioner Pisney?**

23 **A** Well, again, it was this issue of Ms. Boyer
24 asking to have her blood pressure taken, and her
25 blood pressure was elevated and so they contacted

1 Nurse Practitioner Pisney.

2 **Q And did Nurse Practitioner Pisney give any**
3 **instructions as to how to help treat the blood**
4 **pressure concerns?**

5 A Yes. She gave instructions in terms of
6 medication administration, blood pressure
7 rechecks and parameters to call her back.

8 **Q Did Nurse Pisney instruct to give a dose of**
9 **Clonidine -- I'm not sure if I'm pronouncing that**
10 **right -- to Ms. Boyer and then to recheck her**
11 **blood pressure at 3:45?**

12 A I know that she -- let me preface my answer by
13 saying again I was not asked to review Nurse
14 Practitioner Pisney's care, clinical orders,
15 outside of my scope.

16 So yes, I reviewed the timeline and the
17 things that she did, but I don't have all of that
18 committed to memory.

19 I do know, to answer your question, she did
20 order a dose of Clonidine and she did order a
21 blood pressure recheck again with parameters
22 provided for them to call back.

23 **Q And do you know if Nurse Pisney left instructions**
24 **on what to do if Ms. Boyer's blood pressure was**
25 **still high after five o'clock?**

1 MR. KNOTT: Form. Scope. Foundation.

2 A Yeah, I don't know about five o'clock. This was
3 an ongoing conversation. So I know that an
4 additional dose of Clonidine was given and
5 additional recheck done. That's documented in
6 the record.

7 Q (By Ms. Irene, continuing) And do you know if
8 after that second additional recheck if Nurse
9 Pisney left any instructions for what to do after
10 that second check if Ms. Boyer's blood pressure
11 was still high?

12 MR. KNOTT: Form.

13 A Well, it wouldn't -- it wouldn't work that way,
14 so she would have given the instruction before.
15 So it would -- she would say give this Clonidine,
16 recheck the blood pressure, and if it's, whatever
17 her parameters were, if it's below those
18 parameters -- or call me back if it's above those
19 parameters. And so if it's not, if it's below
20 those parameters, then there's not a need to call
21 back.

22 Q (By Ms. Irene, continuing) Do you know what a
23 hypertensive crisis is?

24 A Yes.

25 Q Is a hypertensive crisis when systolic pressure

1 is over 180 and/or diastolic is over 120?

2 A You know, that's outside of my scope in terms of
3 the current definition.

4 Q Okay. One moment. I'm going to share my screen
5 again.

6 A Have I missed a question?

7 Q I apologize. I forgot to take myself off of
8 mute.

9 Ms. Pearson, have you seen this before?

10 A Yes, I have.

11 Q Did you review this -- have you reviewed this
12 document before?

13 A Yes, I have.

14 Q And is this an email that was sent from Shasta
15 Parker?

16 A Yes, it is.

17 Q And did Shasta Parker send this email to a jail
18 nurse email?

19 A Well, there is an email address that says
20 jail.nurse@co.monroe.wi.us.

21 Q And is one of the people cc'd on this email Amber
22 Fennigkoh?

23 A Yes.

24 Q And in this email does Sergeant Shasta Parker say
25 that Ms. Boyer was complaining of feeling hot and

1 sweaty and not being able to breathe?

2 A Yes.

3 Q And does she say that -- does Officer Parker say
4 that Ms. Boyer's blood pressure was really
5 high?

6 A That's what she wrote.

7 Q And at the bottom of this email did Officer
8 Parker say that she wanted to make sure that --
9 did Officer Parker say she wanted to make sure
10 you were aware for follow-up purposes, if
11 necessary?

12 A Yes.

13 Q Do you know why Sergeant Parker would have sent
14 this email to Amber Fennigkoh?

15 MR. KNOTT: Form. Foundation.

16 A Well, she actually sent it to the jail nurse
17 email. So I don't know who the other nurses are
18 who work there, but so Amber is cc'd on that.
19 But this is just a great communication, frankly,
20 just to provide information to the nursing staff
21 when they are back in the building.

22 All of this information is in the record,
23 but she went over and above here and just
24 provided a quick email with an overview of what
25 occurred.

1 Q (By Ms. Irene, continuing) Yes. My apologies.

2 My question should be, do you know why Amber
3 Fennigkoh was cc'd on this email?

4 A No. I don't know -- I would have to speculate,
5 but I don't know. I don't believe that Shasta
6 Parker testified about why she included her. But
7 obviously, they had had conversations.

8 Q In your experience with updates, with health
9 updates like this in a correctional facility, are
10 you aware of any type of protocols for who to cc
11 on health update emails?

12 A I don't -- the health information is in the
13 medical record. This is just an additional
14 communication. It's not to take the place of the
15 record. It's just an additional communication.

16 Q Is there anything that you believe Nurse
17 Fennigkoh could have done differently?

18 MR. KNOTT: Object. The question is
19 vague and overly broad.

20 A In regard to something specific or?

21 Q (By Ms. Irene, continuing) Is there anything that
22 you believe Nurse Fennigkoh could have done
23 differently to provide better care for
24 Ms. Boyer?

25 A No. No. Nurse Fennigkoh exceeded the standard

1 of care, frankly. She -- she was off duty, had
2 clocked out at 9:30 on Saturday night and stayed
3 off the clock to assist with interviewing and
4 asking questions to Ms. Boyer.

5 And she placed her in medical observation.
6 She initiated medical observation. She did a
7 referral to mental health just because she felt
8 Ms. Boyer was stressed and had mental health take
9 a look at her. And she contacted -- she talked
10 with the husband. She tried to get medication
11 information. Tried to get diagnosis information.
12 Sent emails to staff saying the husband's coming.

13 When he arrives with the information, which
14 didn't happen until 1 in the morning-ish, she
15 said whenever he gets there, call Nurse
16 Practitioner Pisney with this information.

17 I mean, she did everything that she could do
18 within her scope and licensure and went over and
19 above. She fielded a phone call at six o'clock
20 after she had clocked out at 5:30.

21 I mean, she's -- it's evident she is
22 dedicated to her patients and was trying to do
23 what she could for Ms. Boyer.

24 **Q Did you -- did you form an opinion about the**
25 **adequacy of the chest pain protocol form used in**

1 **this case?**

2 A No. No, I did not.

3 Q **Did you form an opinion in this case as to the**
4 **lack of morbidity and mortality reviews by ACH in**
5 **this case?**

6 MR. KNOTT: Object to the form.

7 A I did -- I was asked to review Nurse Fennigkoh's
8 care and treatment.

9 Q **(By Ms. Irene, continuing) So I'm sorry, I'm just**
10 **going to ask again.**

11 So did you form an opinion in this case
12 about the lack of morbidity and mortality reviews
13 by ACH?

14 MR. KNOTT: Form.

15 A I did not form an opinion in any way about the
16 presence or lack or anything about a mortality
17 review.

18 Q **(By Ms. Irene, continuing) Did you form an**
19 **opinion in this case about the use or lack of use**
20 **of an EKG?**

21 MR. KNOTT: Form.

22 A No.

23 MS. IRENE: Okay. I can just take a
24 break for a couple minutes again so I can go
25 over my notes.

1 THE VIDEOGRAPHER: And we are going off
2 the record at 12:48 p.m.

3 (Off the record)

4 THE VIDEOGRAPHER: We are back on the
5 record for the deposition of Kim Pearson
6 being conducted by videoconference. Today is
7 February 26th, 2025, and it is 12:59 p.m.
8 Central.

9 Q (By Ms. Irene, continuing) Ms. Pearson, I really
10 do not have many more questions for you. We are
11 nearing the end. Like I said, I can't speak for
12 everyone else, but we are.

13 Did you form an opinion as to the adequacy
14 of ACH's training materials?

15 A I reviewed some of the training materials. I did
16 not -- I was not asked to review those from that
17 perspective.

18 What I can say about what I looked at was
19 that based on RN Fennigkoh's actions and
20 treatment, that she clearly had been trained. So
21 she was, again, performing and meeting the
22 standard of care appropriately.

23 Q Okay. Is my understanding correct that
24 independent of Amber Fennigkoh, you did not form
25 an opinion -- you did not form an opinion on

1 **ACH's training materials?**

2 MR. KNOTT: Object to the form of the
3 question.

4 A I'm sorry, go ahead.

5 MR. KNOTT: I objected to the form of
6 the question, but I think you answered.

7 A Just as I said before, ACH in terms of --
8 reflected in the services reflected in Nurse
9 Fennigkoh's actions and care and treatment,
10 she -- the training was appropriate.

11 Q **(By Ms. Irene, continuing) In your report you**
12 **don't reference any specific ACH orientations or**
13 **training policies or manuals and give a**
14 **conclusion about their adequacy, do you?**

15 A No, I don't believe so. Again, you know, I was
16 asked to review this in terms of RN Fennigkoh and
17 meeting the standard of care and if there was any
18 evidence that she disregarded in any way
19 Ms. Boyer, so.

20 Again, it all -- her actions and the way she
21 conducted her nursing care is reflective of
22 appropriate training.

23 Q **Looking at page 15 of your report, you cite the**
24 **National Commission on Correctional Health Care**
25 **Standards for Health Services in Jails, and I'm**

1 referring to where you cite section JA01, Access
2 to Care.

3 A Yes.

4 Q And you state, Access to care means that -- I
5 apologize. I withdraw the question.

6 And when you're citing that you wrote in
7 your report, Access to care means that in a
8 timely manner, a patient can be seen by a
9 clinician, be given a professional clinical
10 judgment, and receive care that is ordered.

11 Do I have that right?

12 A Yes, that's what I wrote.

13 Q Was Ms. Boyd ever seen in person by a nurse
14 practitioner? Or I'm sorry, I apologize.
15 Ms. Boyer.

16 MR. KNOTT: Form.

17 A I don't believe so, but that's not what the
18 standard requires. It's -- actually, I believe
19 the term is "qualified health professional" which
20 includes a nurse, so she was seen by a nurse.

21 Q (By Ms. Irene, continuing) So to be clear, you're
22 saying that on page 15, looking at the section
23 where it says a patient can be seen by a
24 clinician, you're saying that the term is
25 actually qualified health professional?

1 A Well, I don't have quotes around this, so. I
2 believe it does say "qualified health
3 professional", which by definition is a nurse, a
4 licensed mental health provider, a nurse
5 practitioner. It's any number of qualified
6 licensed providers.

7 Q Okay. One moment. And under this -- I
8 apologize. I withdraw the question.

9 Looking again at the Standards for Health
10 Services in Jail section JA01, is part of the
11 standard of care that a face-to-face exam is
12 given?

13 MR. KNOTT: Object to the form. It's
14 vague.

15 A Well, no, and these standards are not standard of
16 care. This is not standard of care. These are
17 accreditation standards. But the answer is still
18 no.

19 Q (By Ms. Irene, continuing) Okay. So when it says
20 access to care means that in a timely manner a
21 patient can be seen by a clinician or a qualified
22 health professional, what does "seen by" mean?

23 A Well, I did not write the standard.

24 Q If you do not know, you are more than -- I don't
25 want you to answer something that you don't know

1 the answer to. If you do not know, that is an
2 acceptable answer.

3 A Right. I didn't -- I didn't write the standard.
4 It's just access to care that a patient is seen
5 by a qualified healthcare professional. So I
6 don't know what they meant when they wrote that.

7 But regardless, she was seen by a qualified
8 health professional.

9 Q Okay. I'm going to share my screen again.

10 Ms. Pearson, have you seen this document
11 before?

12 A Perhaps. I would need to reread it.

13 Are you going to ask me -- should I read it?
14 Are you going to ask me questions about it?

15 Q Yes. Please take a moment to reread it.

16 MR. KNOTT: Madison, when she's done,
17 would you mind scrolling down for a Bates
18 number? Wait until she says she's done.

19 MS. IRENE: Yes. Thank you.

20 A Okay.

21 Q (By Ms. Irene, continuing) Okay. And for the
22 record, the document that Ms. Pearson was
23 reviewing was Monroe County Bates No. 017959.

24 Is this an email sent to -- or sorry, sent
25 from Amber Fennigkoh?

1 A Yes.

2 Q And in this email does Ms. Fennigkoh express
3 concerns about sending -- about the frequency
4 with which the jail is sending inmates to the
5 emergency room?

6 MR. KNOTT: Vague. Foundation.

7 A I'm going to say no to that. This is -- this
8 email is covering several different things. I --
9 my -- just reading it now, my take on this is
10 that Nurse Fennigkoh is asking questions that I
11 think she's just trying to be concerned about
12 processes and what's, you know, the best way to
13 handle various situations. And I just don't have
14 any more context other than this email.

15 Q (By Ms. Irene, continuing) Ms. Pearson, to be
16 clear, have you seen this email before?

17 A You know, I believe I did, but it really wasn't
18 related to this, the care, what was going on in
19 this particular case.

20 So I believe I saw it. I just didn't pick
21 it apart because it really wasn't relevant to
22 this case from my perspective of what I was asked
23 to do.

24 Q Okay. One moment. Did you form an opinion on
25 whether or not the -- I'm sorry. Hang on one

1 **second.**

2 **Have you seen this email before?**

3 MR. KNOTT: Bates number?

4 MS. IRENE: Yes, I apologize. Thank
5 you.

6 **Q (By Ms. Irene, continuing) Have you seen this**
7 **email before? This is Bates No. Monroe County**
8 **018773.**

9 **A**Again, yes. I believe I reviewed this. But
10 again, I did not -- I didn't spend any time
11 picking it apart again because it wasn't
12 necessarily relevant to what I was asked to do in
13 this particular case.

14 **Q**Have you seen -- sorry. I'm not sure if you
15 heard my question or if I was on mute again.

16 **Have you seen this email before?**

17 **A**I believe so, yes.

18 MR. KNOTT: I think she just
19 answered.

20 **Q**(By Ms. Irene, continuing) Okay. And did you
21 consider it in forming your opinions in this
22 case?

23 **A**No, in terms of this is a discussion about
24 services in general and the best way to manage
25 that, and it really wasn't applicable per se to

1 this case with Ms. Boyer.

2 Q Okay. And just to be clear in case I was on mute
3 when I said this because I'm not sure when I went
4 on, but this is Bates Monroe County 056584.

5 Ms. Pearson, do you believe that people in
6 prison deserve the same access to healthcare as
7 those who are not in prison?

8 MR. KNOTT: Object to the form.

9 A In jail and prison, yes. It's just access to
10 care, as with any venue, looks different based on
11 your resources.

12 So, for instance, if you're in the emergency
13 room and you start to have a stroke there's a
14 doctor right there, you're in the emergency room.

15 If you start to have a stroke at a jail, 911
16 is called and you're transported to the emergency
17 room. So it's access to care. It's just
18 accomplished in a different way based on the
19 resources available.

20 But yes, as we call them patients, not
21 inmates, the patients absolutely deserve access
22 to care and their healthcare needs met. That's
23 the purpose of correctional health care companies
24 providing correctional health.

25 Q (By Ms. Irene, continuing) And do you believe

1 that patients who are incarcerated deserve the
2 same standard of medical care as those who are
3 not incarcerated?

4 MR. KNOTT: Object to the form of the
5 question. Object to the extent it's vague as
6 to "standard". If it's standard of care,
7 it's a legal question. But go ahead.

8 A Could you repeat the question, please.

9 Q (By Ms. Irene, continuing) Do you believe that
10 people who are incarcerated deserve the same
11 standard of medical care as those who are not
12 incarcerated?

13 A Well, again, standard of care is what would the
14 same or similar person do in the same or similar
15 situation. So again, I'm back to it depends on
16 your resources and how you accomplish standard of
17 care.

18 There are -- well, they deserve to have
19 their healthcare needs met, it's just
20 accomplished in different ways based on the
21 venue. As my example before, if you're in the
22 emergency room versus in a jail, you're having a
23 stroke, that's handled two different ways.
24 You're still getting access to care, it just has
25 to be accomplished differently.

1 MS. IRENE: Okay. I have no further
2 questions. Thank you very much for your
3 time, Ms. Pearson.

4 MR. JONES: I do not have questions.

5 MR. HARDY: I have no questions.

6 MR. KNOTT: Ms. Pearson, I have just a
7 couple of clarifications.

8 EXAMINATION

9 BY MR. KNOTT:

10 Q Just prior to the last break a question was asked
11 about whether you had formed an opinion, and I
12 don't remember exactly how it was phrased,
13 whether you had formed an opinion with respect to
14 an EKG, and I think your answer was no.

15 Did you form an opinion as to whether the
16 standard of care required Amber Fennigkoh to send
17 Ms. Boyer to a hospital to get an EKG at any
18 time?

19 A Yes, I do have an opinion about that. And my
20 opinion is that no, Nurse Fennigkoh was never in
21 a position where the standard of care would
22 require her to send Ms. Boyer to the hospital for
23 an EKG. RN Fennigkoh was not even in the
24 building at the time that Ms. Boyer experienced
25 chest pain and she was --

1 Q Okay. And the last question, you were asked
2 questions about NCCHC Standard JA01 Access to
3 Care and how you quoted that, or you cited that
4 on page 15 of your report.

5 A Yes.

6 Q Do you have that in front of you now?

7 A Yes.

8 Q And just with respect -- so the record is clear,
9 with respect to the term "clinician", what is
10 your opinion with respect to the use of the word
11 "clinician" in JA01?

12 A A licensed healthcare staff member. NCCHC they
13 do use the term "qualified healthcare
14 professional."

15 In the back of the standards book they
16 define what that is, and it is a licensed
17 healthcare professional such as a nurse, a
18 licensed mental health worker, a physician. It
19 goes through the gamut of licensed healthcare
20 workers who are able to provide -- who are able
21 to see the patient.

22 Q And is it my understanding you substituted when
23 you're writing your report "clinician" for
24 qualified healthcare provider -- or "qualified
25 healthcare professional"?

1 A Yes.

2 Q And in retrospect, is that a choice you would
3 make again?

4 A In retrospect, I'm changing that when we're
5 finished here today.

6 Q And that's it?

7 A To be clear, yes. Again, it's not in quotes.
8 The standards, the National Commission standards
9 book is many, many, many pages long and there's a
10 lot of information. I mean, I can't, short of
11 photocopying the book and attaching it, just was
12 trying to offer the intent of the standards.

13 So clinician covers licensed healthcare
14 workers, so. But I will change that to make that
15 clearer in the future.

16 MR. KNOTT: Okay. That's all I have.
17 Thank you.

18 THE VIDEOGRAPHER: Is there any
19 follow-up based on that?

20 MS. IRENE: No. No further questions
21 based on that.

22 THE VIDEOGRAPHER: All right. And just
23 before I take us off the record I do have to
24 get orders.

25 So Madison, would you like the

1 transcript or the video?

2 MS. IRENE: Not at this time. No,
3 thank you.

4 THE VIDEOGRAPHER: All right. Douglas,
5 transcript or the video?

6 MR. KNOTT: Not at this time. Thank
7 you.

8 THE VIDEOGRAPHER: All right. Mark,
9 transcript or the video?

10 MR. HARDY: No, thank you.

11 THE VIDEOGRAPHER: And Andrew,
12 transcript or the video?

13 MR. JONES: Same answer. No.

14 THE VIDEOGRAPHER: All right. Then we
15 are going off record. It is 1:20 p.m.
16 Central.

17 (Off the video record)

18 MR. KNOTT: You know, I'm not sure who
19 was asking the question there, but was that
20 transcript? We need a transcript. We're not
21 going to pay for the original, so. That's a
22 thing we play with the Loevy firm, so.

23 I'm going to order a transcript of the
24 deposition, but I'm not going to pay for the
25 original. So if you're going to insist that

1 I pay for the original, then I'm not going to
2 order the transcript.

3 MS. MAKAR: That's fine.

4 MR. KNOTT: So is Loevy going to order
5 the transcript?

6 MS. MAKAR: Why don't you just tell
7 Talia that you don't want a transcript unless
8 the original is ordered, Doug.

9 MR. KNOTT: Yeah, that's what I'm
10 saying.

11 MS. MAKAR: Okay.

12 THE VIDEOGRAPHER: Okay. Understood.

13 MR. KNOTT: Okay.

14 COURT REPORTER: So I just need to, for
15 my mind, nobody is ordering a paper
16 transcript/electronic transcript of
17 Ms. Pearson; is that correct?

18 MS. MAKAR: Yes, not at this time.

19 COURT REPORTER: Mr. Knott; right?

20 MR. KNOTT: Yep. We'll be in touch.

21 (The videoconference deposition of
22 Kimberly Pearson came to a close at
23 approximately 1:20 p.m.)
24
25

* * *

1 STATE OF WISCONSIN)

2 COUNTY OF ST. CROIX)

3 Be it known that I took the videoconference
4 deposition of Kimberly Pearson, on the 26th day of
5 February, 2025, remotely via Zoom;

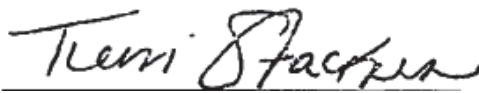
6 that I was then and there a Notary Public in and
7 for the County of St. Croix, State of Wisconsin, and
8 that by virtue thereof I was authorized to administer
9 an oath;

10 that the witness, before testifying, was by
11 me first duly sworn to testify to the whole truth and
12 nothing but the truth relative to said cause;

13 that the testimony of said witness was
14 recorded in stenotypy by myself and reduced to print
15 by means of Computer-Assisted Transcription under my
16 direction, and that the deposition is a true record of
17 the testimony given by the witness to the best of my
18 ability;

19 that I am not related to any of the parties
20 hereto nor interested in the outcome of the action.

21 Dated this 24th day of March, 2025.

22 

23 Terri Stacken, RPR
24 St. Croix County, Wisconsin
25 Commission Expires
10-29-2026

EXHIBITS

EXHIBIT 4 - Narrative Note - previously
marked Exhibit 6

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